Instructions in red with respect to development of the form in the online database:

- Form to be entered one time per subject post-treatment.
- Numerical values formatted xx.x unless otherwise specified.
- Specified numeric ranges are inclusive.
- This form can be separated into sections. The user should be able to click on a link to go directly to any of these sections to begin data entry.
    - Brachytherapy/EBRT Details
    - Plan Details
    - Treatment Delivery and Image Guidance
- It is possible that different users at an institution will fill out this form. For example, a physicist and dosimetrist may fill out different parts of the form.

Brachytherapy/EBRT Details

1. Select the treatment type:
   - $\square_1$ External Beam Radiation Therapy (EBRT) alone
   - $\square_2$ Brachytherapy alone (as monotherapy)
   - $\square_3$ Combination therapy of EBRT and brachytherapy

2. Indicate brachytherapy dose rate type: [If Q1="Brachytherapy alone" or "Combination therapy"]
   - $\square_1$ HDR
   - $\square_2$ LDR

3. Indicate source type: [If Q1="Brachytherapy alone" or "Combination therapy"]
   - $\square_1$ Iridium-192
   - $\square_2$ Palladium-103
   - $\square_3$ Iodine-125
   - $\square_4$ Cesium-131
   - $\square_5$ Other. Please specify: _____

4. Total prescribed brachytherapy dose: _____ Gy [If Q1="Brachytherapy alone" or "Combination therapy"] [between 1 and 90]

5. Indicate any placement procedures prior to simulation related to radiation therapy delivery. Check all that apply. [If Q1="EBRT" or "Combination therapy"]
   - $\square_1$ Gold fiducials
   - $\square_2$ Rectal spacer
   - $\square_3$ Radiofrequency beacons
   - $\square_4$ Rectal balloon
   - $\square_5$ None
   - $\square_6$ Other. Please specify: _____

6. Which modalities were used for contouring for EBRT treatment? Include the primary simulation data set and any that were registered to it. Check all that apply. [If Q1="EBRT" or "Combination therapy"]
   - $\square_1$ CT simulation
   - $\square_2$ PET
   - $\square_3$ MRI
   - $\square_4$ Ultrasound
   - $\square_5$ Other. Please specify: _____

7. Which modalities were used for contouring for brachytherapy treatment? Include the primary simulation data set and any that were registered to it. Check all that apply. [If Q1="Brachytherapy alone" or "Combination therapy"]
   - ❑₁ CT simulation
   - ❑₂ PET
   - ❑₃ MRI
   - ❑₄ Ultrasound
   - ❑₅ Other. Please specify: _____

Plan Details

8. How many EBRT plans were treated? [If Q1="External Beam Radiation Therapy" or "Combination therapy"] [drop-down menu 0-5]

   For each plan, specify:

   a. What volumes were prescribed dose for this plan? Check all that apply.
      - ❑₁ Primary target (prostate or prostate bed, with or without all or part of the seminal vesicles)
      - ❑₂ Lymph node chain
      - ❑₃ Seminal vesicles (if contoured separately and prescribed to a different dose, all or partial)
      - ❑₄ Subvolume of prostate or prostate bed (focal boost)
      - ❑₅ Boost of individual lymph node(s) (spatially distinct if more than one)

   b. Was a PRIMARY TARGET CTV structure defined? [If Q8a="Primary target"]
      - ❑₁ Yes
      - ❑₂ No

   c. What type of margin was used for the PRIMARY TARGET PTV? [If Q8b="Yes"]
      - ❑₁ Uniform in all directions
      - ❑₂ Uniform in all directions except posterior
      - ❑₃ Non-uniform

   d. Specify the uniform margin between the PRIMARY TARGET CTV structure and PTV structure in cm: [If Q8c="Uniform in all directions" or "Uniform in all directions except posterior"] _____ cm

   e. Specify the Posterior margin between the PRIMARY TARGET CTV structure and PTV structure in cm: [If Q8c="Uniform in all directions except posterior"] _____ cm

   f. Specify the non-uniform margin between the PRIMARY TARGET structure and PTV structure in cm: [If Q8c="Non-uniform"]

      | Superior _____ | Anterior _____ | Right _____ |
      | Inferior _____ | Posterior _____ | Left _____ |

   g. Enter the name of the PRIMARY TARGET PTV prescribed to by this plan: _____ [If Q8a="Primary target"] [free text field]

   Note: The name of this structure should match any DICOM structure set uploaded for this patient.

h. Dose delivered to the PRIMARY TARGET by this plan: [If Q8a="Primary target"] [between 1 and 90] _____ Gy

i. If a nodal chain structure was treated, what was the timing used? [If Q8a="Lymph node chain"]
   ❏₁ Simultaneous with primary target
   ❏₂ Sequential plans

j. Was a NODAL CHAIN CTV structure defined? [If Q8a="Lymph node chain"]
   ❏₁ Yes
   ❏₂ No

k. What type of margin was used for the NODAL CHAIN PTV? [If Q8j="Yes"]
   ❏₁ Uniform in all directions
   ❏₂ Uniform in all directions except posterior
   ❏₃ Non-uniform

l. Specify the uniform margin between the NODAL CHAIN CTV structure and PTV structure in cm: [If Q8k="Uniform in all directions" or "Uniform in all directions except posterior"] _____ cm

m. Specify the Posterior margin between the NODAL CHAIN CTV structure and PTV structure in cm: [If Q8k="Uniform in all directions except posterior"] _____ cm

n. Specify the non-uniform margin between the NODAL CHAIN CTV structure and PTV structure in cm: [If Q8k="Non-uniform"]

   Superior _____   Anterior _____   Right _____
   Inferior _____   Posterior _____   Left _____

o. Enter the name of the NODAL CHAIN PTV structure prescribed to by this plan: _____ [If Q8a="Lymph node chain"] [free text field]

p. Dose delivered to the NODAL CHAIN by this plan: [If Q8a="Lymph node chain"] [between 1 and 90] _____ Gy

q. Enter the name of the SEMINAL VESICLES structure prescribed to by this plan: _____ [If Q8a="Seminal vesicles] [free text field]

r. Dose delivered to the SEMINAL VESICLES by this plan: [If Q8a="Seminal vesicles"] [between 1 and 90] _____ Gy

s. Enter the name of the PROSTATE OR PROSTATE BED FOCAL BOOST PTV prescribed to by this plan: _____ [If Q8a="Subvolume of prostate or prostate bed"] [free text field]

t. Dose delivered for the PROSTATE OR PROSTATE BED FOCAL BOOST by this plan: [If Q8a="Subvolume of prostate or prostate bed"] [between 1 and 90] _____ Gy

u. Enter the name of the INDIVIDUAL LN BOOST structure prescribed to by this plan: _____ [If Q8a="Boost of individual lymph node(s)"] [free text field]

v. Dose delivered for the INDIVIDUAL LN BOOST by this plan: [If Q8a="Boost of individual lymph node(s)"] [between 1 and 90] _____ Gy

w. Are there any additional PTVs with different dose levels (such as an additional lymph node)?
   - ❏$_1$ Yes
   - ❏$_2$ No

x. Enter the name of the additional PTV structure prescribed to by this plan: _____ [If Q8w="Yes"] [free text field]

y. Dose delivered to the additional PTV by this plan: [If Q8w="Yes"] [between 1 and 90] _____ Gy

z. Number of fractions **delivered** by this plan: _____

aa. Did the patient receive all of the planned fractions?
   - ❏$_1$ Yes
   - ❏$_2$ No

bb. If no, enter **planned** number of fractions: _____ [If Q8aa="No"]

cc. Planning type used to create this plan:
   - ❏$_1$ Forward planning
   - ❏$_2$ Inverse planning

dd. Delivery type of this plan:
   - ❏$_1$ 3D
   - ❏$_2$ IMRT
   - ❏$_3$ Rotational technique (VMAT or TomoTherapy)
   - ❏$_4$ Protons

Treatment Delivery and Image Guidance

9. What type of imaging was used to verify this patient's setup? Check all that apply.
   - ❏$_1$ kV/MV portal
   - ❏$_2$ CT (CBCT or TomoTherapy CT)
   - ❏$_3$ MR guidance directly before treatment
   - ❏$_4$ Ultrasound
   - ❏$_5$ Other. Please specify: _____
   - ❏$_6$ None (HDR-only treatment)

10. For each imaging type, specify how often the patient was imaged during treatment. [Provide drop-down menu for each response selected in Q9 other than "None"]
   - ❏$_1$ Daily
   - ❏$_2$ Weekly
   - ❏$_3$ Less than daily but more than weekly
   - ❏$_4$ Other. Please specify: _____

11. Was real-time guidance used during treatment?
   - ❏$_1$ Yes
   - ❏$_2$ No

12. What type of real-time guidance was used? Check all that apply. [If Q11="Yes"]

❑1 Real-time kV tracking (such as based on fiducials)
❑2 MR guidance during treatment
❑3 Calypso radiofrequency system
❑4 Other. Please specify: _____