Registration and Inventory of Medical Equipment
Linear Accelerator Equipment
January 2011

Instructions This is the legally required "Registration and Inventory of Medical Equipment" (G.S. § 131E-177) for linear accelerator equipment. Please complete all sections of this Registration and Inventory Form and return by **5:00 p.m. on Monday, February 14, 2011**. We encourage you to email the completed and signed form in a Portable Document Format (pdf) file to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov. If it is not possible to email the completed form, you can mail it to Kelli Fisk, Medical Facilities Planning Section, 2714 Mail Service Center, Raleigh, NC 27699-2714. If you have questions, you can send an email to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov or call the Medical Facilities Planning Section at (919) 855-3865. Thank you!

Section One Contact Information

1. Full legal name of corporation, partnership, individual, or other legal entity that acquired the equipment by purchase, donation, lease, transfer, or comparable arrangement:

   _____
   (Legal Name)

2. Address of the corporation, partnership, individual, or other legal entity that acquired the equipment:

   _____
   (Street and Number)

   _____ (_____) _____
   (City) (State) (Zip) (Phone Number)

3. Chief Executive Officer who is certifying the information in this registration form:

   _____
   (Name) (Title)

   _____
   (Street and Number) (City) (State) (Zip)

   _____ _____
   (Phone Number) (Email)

4. Information Compiled or Prepared by: (Name)_____

   Phone Number (_____)_____ E-mail _____

Section Two Equipment Information

Time Period for Report: ❑ 10/01/2009 – 9/30/2010 ❑ Other time period: _____

(Please make additional copies of pages of this form as needed.)

	Linear Accelerator 1	Linear Accelerator 2	Linear Accelerator 3	Total Units
Serial or I.D. Number				
Model Number				
Manufacturer				
Certificate of Need Project ID				
Date of Purchase				
Purchase Price				
Address where Linear Accelerator is located, including city and county				
Configured for stereotactic radiosurgery?				Total Units
# of unduplicated patients* who received radiation oncology treatment on the linear accelerator				Total Patients

* Patients shall be counted once if they receive one course of radiation oncology treatment using the linear accelerator and more if they receive additional courses of treatment. For example, one patient who receives one course of treatment counts as one, and one patient who receives three courses of treatment counts as three. The number of patients reported here should match the number of patients reported in the Linear Accelerator Treatment Patient Origin chart on page four of this report.

	Treatment Simulator** 1	Treatment Simulator 2	Treatment Simulator 3	Total Units
Serial or I.D. Number				
Model Number				
Manufacturer				
Certificate of Need Project ID				
Date of Purchase				
Purchase Price				
Address where treatment simulator is located, including city and county				
# of unduplicated patients who receive treatment simulation				Total Patients

Name of entity that acquired the equipment (from page one) _____

** "... [m]achine that produces high quality diagnostic radiographs and precisely reproduces the geometric relationships of megavoltage radiation therapy equipment to the patient." (GS 131E-176 (24b))

Section Three **Linear Accelerator Treatment Data** (including Cyberknife® & Similar Equipment)

In the chart below, write the number of procedures, by CPT Code, provided by the entity's linear accelerator(s) during the time period of this report.

CPT Code	Description	# of Procedures
Simple Treatment Delivery		
77401	Radiation treatment delivery	
77402	Radiation treatment delivery (<=5 MeV)	
77403	Radiation treatment delivery (6-10 MeV)	
77404	Radiation treatment delivery (11-19 MeV)	
77406	Radiation treatment delivery (>=20 MeV)	
Intermediate Treatment Delivery		
77407	Radiation treatment delivery (<=5 MeV)	
77408	Radiation treatment delivery (6-10 MeV)	
77409	Radiation treatment delivery (11-19 MeV)	
77411	Radiation treatment delivery (>=20 MeV)	
Complex Treatment Delivery		
77412	Radiation treatment delivery (<=5 MeV)	
77413	Radiation treatment delivery (6-10 MeV)	
77414	Radiation treatment delivery (11-19 MeV)	
77416	Radiation treatment delivery (>= 20 MeV)	
Other Treatment Delivery Not Included Above		
77418	Intensity modulated radiation treatment (IMRT) delivery	
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multisource Cobalt 60 based (Gamma Knife)	
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator	
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	
G0339	(Image-guided) robotic linear accelerator-based stereotactic radiosurgery in one session or first fraction	
G0340	(Image-guided) robotic linear accelerator-based stereotactic radiosurgery, fractionated treatment, 2nd-5th fraction	
	Intraoperative radiation therapy (conducted by bringing the anesthetized patient down to the linac)	
	Pediatric Patient under anesthesia	
	Neutron and proton radiation therapy	
	Limb salvage irradiation	
	Hemibody irradiation	
	Total body irradiation	
Imaging Procedures Not Included Above		
77417	Additional field check radiographs	

Name of entity that acquired the equipment (from page one) _____

Total Procedures	

Section Four Linear Accelerator Treatment Patient Origin

County in which linear accelerator services are provided: _____

Please provide the county of residence for unduplicated patients (see note on page two) served by your facility's linear accelerators during the time period of this report. The total number served should be the same as on page two of this report. This data is needed to calculate linear accelerator service areas.

County	Number of Patients	County	Number Of Patients	County	Number of Patients
1. Alamance		41. Guilford		81. Rutherford	
2. Alexander		42. Halifax		82. Sampson	
3. Alleghany		43. Harnett		83. Scotland	
4. Anson		44. Haywood		84. Stanly	
5. Ashe		45. Henderson		85. Stokes	
6. Avery		46. Hertford		86. Surry	
7. Beaufort		47. Hoke		87. Swain	
8. Bertie		48. Hyde		88. Transylvania	
9. Bladen		49. Iredell		89. Tyrrell	
10. Brunswick		50. Jackson		90. Union	
11. Buncombe		51. Johnston		91. Vance	
12. Burke		52. Jones		92. Wake	
13. Cabarrus		53. Lee		93. Warren	
14. Caldwell		54. Lenoir		94. Washington	
15. Camden		55. Lincoln		95. Watauga	
16. Carteret		56. Macon		96. Wayne	
17. Caswell		57. Madison		97. Wilkes	
18. Catawba		58. Martin		98. Wilson	
19. Chatham		59. McDowell		99. Yadkin	
20. Cherokee		60. Mecklenburg		100. Yancey	
21. Chowan		61. Mitchell			
22. Clay		62. Montgomery		101. Georgia	
23. Cleveland		63. Moore		102. South Carolina	
24. Columbus		64. Nash		103. Tennessee	
25. Craven		65. New Hanover		104. Virginia	
26. Cumberland		66. Northampton		105. Other States	
27. Currituck		67. Onslow		106. Other (specify)	
28. Dare		68. Orange		**Total Number of Patients Served by Your Facility's Linear Accelerators**	
29. Davidson		69. Pamlico			
30. Davie		70. Pasquotank			
31. Duplin		71. Pender			
32. Durham		72. Perquimans			
33. Edgecombe		73. Person			
34. Forsyth		74. Pitt			
35. Franklin		75. Polk			
36. Gaston		76. Randolph			
37. Gates		77. Richmond			
38. Graham		78. Robeson			
39. Granville		79. Rockingham			
40. Greene		80. Rowan			

Name of entity that acquired the equipment (from page one) _____

Section Five **Reimbursement/Payment Source**

Please provide the source of reimbursement/payment for linear accelerator treatment procedures. Total procedures should equal the total number of procedures reported on page three of this report.

Primary Payer Source	Number of Procedures
Self Pay	
Medicare & Medicare Managed Care	
Medicaid	
Commercial Insurance	
Managed Care	
Unreimbursed Care (Indigent/Charity)	
Other (Specify)	
TOTAL	

Section Six **Certification and Signature**

The undersigned Chief Executive Officer or other approved signatory certifies the accuracy of the information contained on all pages of this form.

Print name _____

Signature _____

Date signed _____

Please return the completed form by 5:00 p.m. Monday, February 14, 2011 by email to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov (pdf file), or mail to Kelli Fisk, Medical Facilities Planning Section, 2714 Mail Service Center, Raleigh, NC 27699-2714. If you have questions, you can send an email to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov or call (919) 855-3865.

Thank you!

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