



Registration and Inventory of Medical Equipment
Linear Accelerator Equipment
January 2015

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 form and return to the Medical Facilities Planning Branch by **Friday, January 30, 2015**.

1. Complete and sign the form
2. Return the form by one of two methods:
 - a. Email a scanned copy to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov
 - b. Mail the form to Kelli Fisk, Medical Facilities Planning Branch, 2714 Mail Service Center, Raleigh, NC 27699-2714.

Note: Fixed equipment operated in a facility licensed under a hospital should be reported on that hospital’s license renewal application, and not duplicated on this form.

If you have questions, call Kelli Fisk in the Medical Facilities Planning Branch at (919) 855-3865 or email DHSR.SMFP.Registration-Inventory@dhhs.nc.gov.

Section 1: 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 or approved designee 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) _____ (Email)



Section 2: Equipment and Procedures Information

Time Period for Report: 10/01/2013 – 9/30/2014 Other time period: _____

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

	Linear Accelerator Number __	Linear Accelerator Number __	Total Units
Serial or I.D. Number			
Model Number			
Manufacturer			
Certificate of Need Project ID			
Date of Purchase			
Purchase Price			
Service Site Information: Please include all of the information requested for each location.	Service Site _____ Address _____ _____ City, State, Zip _____ County _____	Service Site _____ Address _____ _____ City, State, Zip _____ County _____	
Configured for stereotactic radiosurgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Total Configured Units
Number 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 4 of this report.

Name of entity that acquired the equipment (from page 1) _____



Section 2: Equipment and Procedures Information continued

	Simulator** Number ____	Simulator Number ____	Total Units
Serial or I.D. Number			
Model Number			
Manufacturer			
Certificate of Need Project ID			
Date of Purchase			
Purchase Price			
Service Site Information: Please include all of the information requested for each location.	Service Site _____ Address _____ _____ City, State, Zip _____ County _____	Service Site _____ Address _____ _____ City, State, Zip _____ County _____	Total Patients
Number of unduplicated patients who receive treatment simulation			

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

Name of entity that acquired the equipment (from page 1) _____



Section 3: 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	Number 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	
Total Procedures		

Name of entity that acquired the equipment (from page 1) _____



Section 4: Linear Accelerator Treatment Patient Origin Data

Please provide the county of residence for unduplicated patients (see note on page 2) 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 2 of this report. This data is needed to calculate linear accelerator service areas.

County in which service was provided: _____

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

Name of entity that acquired the equipment (from page 1) _____



Section 5: 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 2 of this form.

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 6: Certification and Signature

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

Signature _____

Print Name _____

Date signed _____

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