

Simulator Questionnaire

Therapy Remarketing Group



1. Facility name: _____
2. Manufactured by: _____ Model: _____
3. Serial #: _____ Manufacture date: _____ Installation date: _____
4. Is it still installed? Yes No Is it still operational? Yes No
5. What type of generator does it have (manufacturer & model)?: _____
Generator phases: Three phase Single phase
6. Does it have flouro capabilities? Yes No If so, what is the size of the i.i.? _____
Has the i.i. ever been replaced? Yes No If "yes", when? _____
7. Has the x-ray tube ever been replaced? Yes No If "yes", when? _____
8. Does it have last image hold? Yes No
9. How many lasers? _____ Manufacturer and models? _____
10. Number of monitors: _____ Sizes: _____ Manufacturer: _____
11. Does this system include the complete spare parts kit? Yes No
If "no" what parts are missing? _____
12. Facility contacts: Primary: _____ Phone: () _____
Technical: _____ Phone: () _____
Service: _____ Phone: () _____
13. Estimated removal date: _____
14. Additional Information about the system (include accessories, options, etc.)

*Please complete the above questionnaire and fax to TRG at (949) 622-0033.
If you have any questions, call us at (949) 622-0022.*

Linear Accelerator Questionnaire

Therapy Remarketing Group



1. Facility name: _____
2. Manufactured by: _____ Model: _____
3. Serial #: _____ Manufacture date: _____ Installation date: _____
4. Is it still installed? Yes No Is it still operational? Yes No
5. Photon energies: _____ Electron energies: _____
6. Beam hours: _____ Filament hours: _____
7. Does the system have a Multi-leaf collimator? Yes No If yes, what kind? _____
8. What software version is on the system? _____ Does it have DMLC Software? Yes No
9. Primary components:
 - Has the klystron/magnetron been replaced? Yes No If "yes", when? _____
 - Has the Waveguide/Gun & Target been replaced? Yes No If "yes", when? _____
 - Has the thyatron been replaced? Yes No If "yes", when? _____
 - Has the RF driver been replaced? Yes No If "yes", when? _____
10. Does this system have a beamstopper? Yes No If "yes" is it retractable? Yes No
11. Couch type: _____ Does unit have Independent Jaws? Dual Single None
12. What version of accessories? _____
13. Is there a complete set of cones/wedges? Yes No Sizes? _____

14. What modifications and/or upgrades have been made to this system? _____

15. Does this system include the complete spare parts kit? Yes No
If "no" what parts are missing? _____
16. Contacts: Primary: _____ Phone: () _____
Technical: _____ Phone: () _____
Service: _____ Phone: () _____
17. Estimated removal date: _____
18. Additional Information about the system (include accessories, options, etc.)

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*Treatment Planning System /
Misc. Equipment Questionnaire*

Therapy Remarketing Group



1. Facility name: _____
2. Manufactured by: _____ Model: _____
3. Serial #: _____ Manufacture date: _____ Installation date: _____
4. Is it still installed? Yes No Is it still operational? Yes No
5. CPU: _____ RAM Memory: _____ Hard Disk Space: _____
6. Include: Printer/Scanner/Plotter? : _____
7. Software Version? _____ Is ALL required software included with unit? Yes No
8. Have there been any modifications/upgrades to this system? If so, please specify: _____

9. Accessories Included: _____
10. Special Features or requirements: _____
11. Is equipment still currently manufactured and supported? _____
12. Facility contact information:
Primary Contact: _____ Phone: () _____
Technical Contact: _____ Phone: () _____
13. Estimated removal date: _____ Reason for removal: _____
14. Additional Information about the system (include accessories, options, etc.)

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If you have any questions, call us at (949) 622-0022.*

*Orthovoltage/Superficial
Questionnaire*

Therapy Remarketing Group



1. Facility name: _____
2. Manufactured by: _____ Model: _____
3. Serial #: _____ Manufacture date: _____ Installation date: _____
4. Is it still installed? _____ Is it still operational? _____
5. Have there been any modifications/upgrades to this system? If so, please specify: _____

6. Facility contact information:
Primary Contact: _____ Phone: () _____
Technical Contact: _____ Phone: () _____
7. Who has been servicing this system?
Name: _____ Phone: () _____ How long: _____
8. When will the system be available for removal: _____
9. Additional Information about the system (include accessories, options, etc.)

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If you have any questions, call us at (949) 622-0022.*

HDR
Questionnaire

Therapy Remarketing Group



1. Facility name: _____
2. Manufactured by: _____ Model: _____
3. Serial #: _____ Manufacture date: _____ Installation date: _____
4. Is it still installed? _____ Is it still operational? _____
5. What type of computer (model, CPU, memory, hard disk)? _____

6. What version of software? _____
7. What applicators and accessories are included? _____

8. Have there been any modifications/upgrades to this system? If so, please specify: _____

9. Facility contact information:
Primary Contact: _____ Phone: () _____
Technical Contact: _____ Phone: () _____
10. Who has been servicing this system?
Name: _____ Phone: () _____ How long: _____
11. When will the system be available for removal: _____
12. Additional Information about the system (include accessories, options, etc.)

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If you have any questions, call us at (949) 622-0022.*

CT-Simulator Questionnaire

Therapy Remarketing Group



1. Facility name: _____
2. Manufactured by: _____ Model: _____
3. Serial #: _____ Manufacture date: _____ Installation date: _____
4. Is it still installed? Yes No Is it still operational? Yes No
5. Bore width (cm)? _____ FOV (cm)? _____
6. What type of tube does it have (manufacturer & model)? _____
Has the tube ever been replaced? Yes No If "yes", when? _____
7. Current tube exposures: _____ Current number of gantry rotations? _____
8. Has the system been upgraded? Yes No If yes, when? _____
9. Current software level installed? _____
10. What type of laser camera / imager? _____
11. How many positioning lasers? _____ Manufacturer and model(s)? _____
12. What type of CT Simulation workstation is included? _____
13. CT Simulator software version? _____
14. What type of flat-table top is on the system (indexed? Mfg?) ? _____
15. Cosmetic condition of the unit (scale : *worst*1-10 *best*) _____
16. Does this system include the complete set of accessories? Yes No
If "no" what items are missing? _____
17. Facility contacts: Primary: _____ Phone: () _____
Technical: _____ Phone: () _____
18. Who has been servicing this system? Name: _____
Phone: () _____ How long: _____
19. Estimated removal date: _____
20. Additional Information about the system (include accessories, options, etc.)

Please complete the above questionnaire and fax to TRG at (949) 622-0033 .If you have any questions, call us at (949) 622-0022.

**MRI
Questionnaire**

Therapy Remarketing Group



1. Facility name: _____
2. Manufactured by: _____ Model: _____
3. Serial #: _____ Manufacture date: _____ Installation date: _____
4. Is it still installed? Yes No Is it still operational? Yes No
5. Bore dimensions (length and width)? _____
6. Field Strength (Tesla)? _____
7. Self Shielded? Yes No
8. What type of tube does it have (manufacturer & model)?: _____
Has the tube ever been replaced? Yes No If "yes", when? _____
9. Has the system been upgraded? Yes No If yes, when? _____
10. Current software level installed? _____
11. What type of laser camera / imager? _____
12. How many positioning lasers? _____ Manufacturer and model(s)? _____
13. Cosmetic condition of the unit (scale : *worst*1-10 *best*) _____
14. Does this system include the complete set of accessories? Yes No
If "no" what items are missing? _____
15. Facility contacts: Primary: _____ Phone: () _____
Technical: _____ Phone: () _____
16. Who has been servicing this system? Name: _____
Phone: () _____ How long: _____
17. Estimated removal date: _____
18. Additional Information about the system (include COILS (very important) accessories, options, etc.)

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If you have any questions, call us at (949) 622-0022.*