Utilization of paperless recordkeeping process is becoming mandatory under new and existing government regulations. While it is possible to implement the transition from paper and film based recordkeeping to paperless and filmless using a “head on” approach, it may be proven costly and inefficient. It is very beneficial to approach this transition in a systematic and thoughtful way to assure that the quality and accessibility of patient information is not compromised, but improved during such transition.

Clinical flow in a typical department of Radiation Oncology includes processing and storing multitude of data related to patient health, treatment plan parameters, diagnostic and planning images, treatment records, including localization imaging. In addition to that extensive follow-up data is stored. All this data has to be stored indefinitely, yet be readily available for access. A complete record should also include and patient-specific QA tests.

This lecture will provide a general overview of a typical data flow in a department of radiation oncology, and application of paperless tools available in Aria (Varian Medical Systems, Palo Alto, CA).

Learning Objectives:
1. Understand the documentation requirements for the clinical flow in a Radiation Oncology Department
2. Understand the tools available within the vendor provided electronic patient record keeping system
3. Understand the need to modify and adjust the paper-based clinical flow when switching to paperless, to increase efficiency and convenience of accessing evidence data.