DIAGNOSTIC TECHNOLOGY CONSULTANTS, INC.
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Mission, Kansas 66205
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statphysics@dtcinc.com
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FETAL Dose Calculation Request
COMPUTED TOMOGRAPHY EXAMINATIONS

Provide the information requested below for each CT exam. If there are more than 3 procedures, submit both pages. Items in red are mandatory.
Upon completion of this form:

1) Save the file(s) to your computer.
2) **Upload** at https://www.dtcinc.com/dtc-form-uploads.html.

Also please submit dose reports generated by the CT equipment for each of the exams described on form.

Institutional Information:

Institution Name: Contact Number:

Contact Person: Fax Number:

Date Contacted:

Patient Information: (do not submit the patient's name)

Medical Record #: Approximate Conception Date:

Patient's Weight: ☐ lbs ☐ kg Patient's Height: ft in

Equipment Information:

CT Scanner Used (brand, model, etc.): Room #:

Procedure Information: (Total number of procedures)

	CT Procedure #1	CT Procedure #2	CT Procedure #3
Name of Procedure:*			
Date of Procedure:*			
Anatomy Thickness:*			
Anatomical Scan Limits:*			
# of Slices:*			
Was the uterus included?:*	☐ Yes, # of slices: ☐ No	☐ Yes, # of slices: ☐ No	☐ Yes, # of slices: ☐ No
Detector Configuration:*			
Axial or Helical:*			
Pitch (for Helical):*			
Displayed CTDIvol:*			
DLP:*			
Maximum mA:*			
Scan Time/Rotation:*			
mAs:*			
kVp:*			

*Mandatory

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