

**FETAL Dose Calculation Request
NUCLEAR MEDICINE EXAMINATIONS**

Provide the information requested below for each Nuclear Medicine 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 Nuclear Medicine 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:

Nuclear Medicine Equipment Used (brand, model, etc.):

Procedure Information: (Total number of procedures)

**Nuclear Medicine
Exam #1**

**Nuclear Medicine
Exam #2**

**Nuclear Medicine
Exam #3**

Name of Procedure:*

Date of Procedure:*

Radiopharmaceutical:*

Dose:*

Additional Information:*

***Mandatory**

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in

Equipment Information:

Nuclear Medicine Equipment Used (brand, model, etc.):

Procedure Information: (Total number of procedures)

**Nuclear Medicine
Exam #4**

Name of Procedure:*

Date of Procedure:*

Radiopharmaceutical:*

Dose:*

Additional Information:*

**Nuclear Medicine
Exam #5**

**Nuclear Medicine
Exam #6**

***Mandatory**