DIAGNOSTIC TECHNOLOGY
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PATIENT Dose Calculation Request
NUCLEAR MEDICINE EXAMINATIONS

Provide the information requested below for each Nuclear Medicine exam; if more than 3 procedures, complete and submit additional forms as needed. Upon completion of this form, save the file(s) and **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 #:

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		