

PATIENT 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 #:

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:*

Slice Thickness:*

Slice Spacing:*

Detector Configuration:*

Axial or Helical:*

Pitch (for Axial):*

Displayed CT DIvol:*

DLP:*

Maximum mA:*

Scan Time/Rotation:*

mAs:*

kVp:*

***Mandatory**

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