

**FETAL** Dose Calculation Request

**Radiographic & Fluoroscopic Examinations**

Provide the information requested below for each Radiographic and Fluoroscopic 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 Radiographic equipment if available for each of the exams described on form.

**Institutional Information:**

Institution Name:

Contact Number:

Contact Person:

Contact Email:

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

**Procedure Information:** (Total number of procedures)

	Rad/Fluoro Procedure #1	Rad/Fluoro Procedure #2	Rad/Fluoro Procedure #3
Name of Procedure:*			
Date of Procedure:*			
Room#/Portable#:			
Anatomy Thickness:*			
Orientation (AP, PA, Lat):*			
Was the uterus in the primary beam?:*	Yes*    No	Yes    No	Yes    No
Fluoro time (min):*			
# Digital Runs:*			
Frames / sec:*			
Total # Frames:*			
mAs:*			
kVp:*			
Total Air Kerma (mGy):*			
DAP (mGycm <sup>2</sup> ):*			
<b>RADIOGRAPHIC</b>			
# and Sizes of Views:*			
mAs:*			
kVp:*			
<b>*Mandatory</b>			

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Approximate Conception Date:

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lbs

kg

Patient's Height:

ft

in

**Procedure Information:** (Total number of procedures)

	Rad/Fluoro Procedure #4	Rad/Fluoro Procedure #5	Rad/Fluoro Procedure #6
Name of Procedure:*			
Date of Procedure:*			
Room#/Portable#:			
Anatomy Thickness:*			
Orientation (AP, PA, Lat):*			
Was the uterus in the primary beam?:*	Yes No	Yes No	Yes No
Fluoro time (min):*			
# Digital Runs:*			
Frames / sec:*			
Total # Frames:*			
mAs:*			
kVp:*			
Total Air Kerma (mGy):*			
DAP (mGycm <sup>2</sup> ):*			
<b>RADIOGRAPHIC</b>			
# and Sizes of Views:*			
mAs:*			
kVp:*			
<b>*Mandatory</b>			