

FETAL Dose Calculation Request

CT 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:

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

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 involved?:*

Yes, # of slices:

No

Yes, # of slices:

No

Yes, # of slices:

No

Detector Configuration:*

Axial or Helical:*

Pitch (for Axial):*

Displayed CTDivol:*

DLP:*

Maximum mA:*

Scan Time/Rotation:*

mAs or effective mAs:*

kVp:*

***Mandatory**

FETAL Dose Calculation Request

CT 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:

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

Equipment Information:

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

Room #:

Procedure Information: (Total number of procedures)

CT Procedure #4

CT Procedure #5

CT Procedure #6

Name of Procedure:*

Date of Procedure:*

Anatomy Thickness:*

Anatomical Scan Limits:*

of Slices:*

Was the uterus involved?:*

Yes, # of slices:

No

Yes, # of slices:

No

Yes, # of slices:

No

Detector Configuration:*

Axial or Helical:*

Pitch (for Axial):*

Displayed CTDivol:*.DLP:*

Maximum mA:*

Scan Time/Rotation:*

mAs or effective mAs:*

kVp:*

***Mandatory**