

**PATIENT 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:

Contact Email:

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**

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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 #4**

**Nuclear Medicine  
Exam #5**

**Nuclear Medicine  
Exam #6**

Name of Procedure:\*

Date of Procedure:\*

Radiopharmaceutical:\*

Dose:\*

Additional Information:\*

**\*Mandatory**