



Alliance Medical Physics LLC

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REQUEST FOR SHIELDING RECOMMENDATION BY MEDICAL PHYSICIST

~PLEASE NOTE TYPICAL ESTIMATED TURN AROUND TIME IS 2-4 WEEKS ONCE ALL COMPLETE INFORMATION IS RECEIVED~

<i>Facility Information</i>	<i>Physical Location</i>	<i>Installation/Sales Vendor (*Required for SC DHEC)</i>
Facility Name (as registered):		
Address:		
City, State, Zip:		
State X-Ray Registration #:		*
Phone Number:		
Fax Number:		
Email:		
Contact and Title:		
Additional Contact and Title:		
<i>DEADLINE FOR PROJECT:</i>		
<i>INSTALLATION DATE:</i>		*

TYPE OF CONSTRUCTION (CHECK ALL THAT APPLY)

- New Facility* New Construction* Existing Room
 Unit Replacement Other: _____

**Must complete a new client questionnaire in order for Alliance Medical Physics to release the shielding design. This includes new construction that is separate from an existing location but is still part of a hospital system.*

ROOM INFORMATION (REQUIRED FOR ALL UNITS)

Room# / Name / Floor Level: _____

Room Height (from ceiling concrete slab to floor concrete slab): _____

Minimum thickness of concrete ceiling slab: _____ Area ABOVE room: _____

Minimum thickness of concrete floor slab: _____ Area BELOW room: _____

EXISTING BUILDING MATERIALS (REQUIRED FOR ALL UNITS)

Wall Location/Description	Adjacent Area (i.e., corridor, xray, office, etc.)	Existing Lead Equivalence

EQUIPMENT INFORMATION (FILL IN FOR LINE NEEDED)

	Manufacturer/Model	Max kVp	Max mA	Field Size	Patients/40 hours	Scan Time	
<input type="checkbox"/> Radiographic							Isotopes for Nuclear Medicine:
<input type="checkbox"/> Rad/Fluoro					#Rad: #Fluoro:		
<input type="checkbox"/> Stationary C-Arm							
<input type="checkbox"/> Angio/IR/Specials							
<input type="checkbox"/> Cardiac Cath							
<input type="checkbox"/> Mammography							
<input type="checkbox"/> Stereotactic Biopsy							
<input type="checkbox"/> Computed Tomography					#Abdo: #Head:		
<input type="checkbox"/> O-Arm/G-Arm					#Fluoro: #CT:		
<input type="checkbox"/> Dental - Intraoral							
<input type="checkbox"/> Dental - Panoramic							
<input type="checkbox"/> Dental - Cone Beam CT							
<input type="checkbox"/> PET or PET/CT					#PET: #CT:		
<input type="checkbox"/> SPECT/CT							
<input type="checkbox"/> Gamma Camera							
<input type="checkbox"/> Nuclear Medicine Rooms							

FINAL CHECKLIST (REQUIRED ITEMS)

- Floor plan of the entire facility indicating the location of the relevant room(s).
- Layout of room showing equipment location (typically provided by manufacturer/installer).
- Scale or dimension on drawing in order to scale/adjust drawings to appropriate size.
- Description of all adjacent areas around the indicated room (i.e., type of space: office, restroom, dressing room, break room, exam room, reading room, corridor, waiting, etc. If exterior – indicate which floor.
- The diagram **MUST** have the following shown on the diagram:
 - Location of control panel and control switch
 - View window
 - Patient table
 - Location of x-ray producing equipment shown on diagram
 - Chest/Wall bucky shown on diagram for Radiographic, Chest Radiographic or Rad/Fluoro (if applicable).
 - Doors & Windows
 - **For CT, PET/CT, SPECT/CT, CBCT, DEXA – Scatter Plot / Isodose Curve is REQUIRED – this is provided by the manufacturer.**
 - Other: _____

Email ALL requested items to shielding@alimedphys.com