

Request for Nuclear Medicine Fetal Dose Calculation
by Medical Physicist

Please complete the questionnaire below for each Nuclear Medicine scan performed so that we may prepare an accurate fetal dose estimation.

<i>Facility Information</i>			
Facility Name:			
Name of person requesting Fetal Dose Estimate:			
Name of person to receive Fetal Dose Estimate (if different):			
Phone Number:		Fax Number:	
<input type="checkbox"/> Please email Fetal Dose letter to:			

<i>Patient and Exam Information</i>	
Patient MRN:	
Exam type ():	
Date(s) of scan(s):	
Estimate week of pregnancy at time of scan:	
Body Habitus:	<input type="checkbox"/> XL <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> S
Comments:	

<i>Additional information:</i>	
Amount and Form of Radionuclide used:	mCi
	mCi

Comments:		

Return this completed form and requested information to:

Alliance Medical Physics

2500 Abbey Court • Alpharetta, GA 30004

770.751.9707 • (fax) 770.753.4305