Request for Fetal Dose Calculation by Medical Physicist

Please complete the questionnaire below with ***all*** requested information
for each scan performed so that we may prepare an accurate fetal dose estimation.

Facility Information			
Facility Name:			
Name of person requesting Fetal Dose Estimate:			
Name of person to receive Fetal Dose Estimate (if different):			
Phone Number:		Fax Number:	
☐ Please email Fetal Dose letter to:			

Patient and Exam Information	
Patient MRN:	
Exam type (Head, chest, abdomen, pelvis, etc):	
Date(s) of scan(s):	
Estimate week of pregnancy at time of X-ray:	
Body Habitus:	☐ XL ☐ L ☐ M ☐ S
Comments:	

X-ray Scanner Information	
X-ray Make and Model:	
Scanner location (i.e. Room Number, Imaging Center, etc):	

Scan Technique					
kVp:	___	mA:	___ ☐	Exposure time	____ sec
Views:					
☐					
☐					
☐					
Comments:	List number of exams and views;				

Return this completed form and requested information to:

Alliance Medical Physics

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