

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.

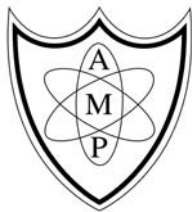
<i>Facility Information</i>			
Facility Name:			
Name of person requesting Fetal Dose Estimate:			
Name of person to receive Fetal Dose Estimate (if different):			
Phone Number:		Fax Number:	
<input type="checkbox"/> Please email Fetal Dose letter to:			

<i>Patient and Exam Information</i>	
Patient MRN:	
Exam type (Head, chest, abdomen, pelvis, etc):	
Date(s) of scan(s):	
Estimate week of pregnancy at time of X-ray:	
Body Habitus:	<input type="checkbox"/> XL <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> S
Comments:	

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

<i>Scan Technique</i>			
kVp:	___	mA:	___ <input type="checkbox"/>
Exposure time	___ sec		
Views:			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
Comments:	List number of exams and views;		

Return this completed form and requested information to:



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