# ***Request for CT Effective Dose Calculation by Medical Physicist***

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

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

| *Patient and Exam Information* | |
|---|---|
| Patient MRN: | |
| Exam type (Head, chest, abdomen, pelvis, etc): | |
| Date(s) of CT scan(s): | |
| | |
| Body Habitus: | ☐XL ☐L ☐M ☐S |
| Comments: | |

| *CT Scanner Information* | |
|---|---|
| Scanner Make and Model: | |
| Scanner location (i.e. Room Number, Imaging Center, etc): | |

| *Scan Technique* | | | | | |
|---|---|---|---|---|---|
| kVp: | ___ | mA: | ____ ☐with Smart Beam | Exposure time/rotation: | _____ sec |
| Slice Thickness(h): | | | _____mm | Detector Configuration( i.e.1.25x8): | |
| ☐For Axial Scanners: Table feed between slices (TF): | | | | | |
| ☐For Helical single-slice Scanners: | | | Table Feed per 360° rotation ($TF_H$): | | |
| | | | Pitch ($TF_H$/h): | | |
| | | | # Slice acquired simultaneously (N): | | |
| ☐For Helical multi-slice Scanners: | | | Pitch Volume ($TF_H$/hN): | | |
| Comments: | | | | | |

| *Scan Mode and Range* | | |
|---|---|---|
| **Scan Mode** | **Scan Range** | |
| Contrast: | ☐ With Only ☐ Without Only ☐ With & Without | |
| ☐ Axial | Total number of slices per series: | |
| ☐ Helical (single & multi-slice) | Total scan length per series: | |
| | Total number of rotations per series: | |
| Additional Comments: | | |
| | | |

*Return this completed form and requested information to:*


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