

## *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.

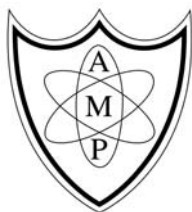
<i>Facility Information</i>			
Facility Name:			
Name of person requesting Fetal Dose Estimate:			
Name of person to receive Fetal Dose Estimate (if different):			
Phone Number:		Fax Number:	
<input type="checkbox"/> Please email Fetal Dose letter to:			

<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:*



**Alliance Medical Physics**

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