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:

Alliance Medical Physics

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