DIAGNOSTIC TECHNOLOGY CONSULTANTS, INC.
DTC
5930 Roe Avenue, Suite 201
Mission, Kansas 66205
913-236-6000 (Direct Line)
Toll Free: 800-753-4DTC (4382)
thull@dtcinc.com
statphysics@dtcinc.com
www.dtcinc.com

FETAL Dose Calculation Request
CT Examinations

Provide the information requested below for each Nuclear Medicine exam. If there are more than 3 procedures, submit both pages. Items in red are mandatory.
Upon completion of this form:

1) Save the file(s) to your computer.
2) **Upload** at https://dtcinc.com/form-upload-1.

Also please submit dose reports generated by the Nuclear Medicine equipment for each of the exams described on form.

Institutional Information:

Institution Name: Contact Number:
Contact Person: Contact Email :
Date Contacted:

Patient Information: (**DO NOT** submit the patient's name)

Medical Record #: Approximate Conception Date:
Patient's Weight: ☐ lbs ☐ kg Patient's Height: ft in

Equipment Information:

CT Scanner Used (brand, model, etc.): Room #:

Procedure Information: (Total number of procedures)

	CT Procedure #1	CT Procedure #2	CT Procedure #3
Name of Procedure:*			
Date of Procedure:*			
Anatomy Thickness:*			
Anatomical Scan Limits:*			
# of Slices:*			
Was the uterus involved?:*	☐ Yes, # of slices: ☐ No	☐ Yes, # of slices: ☐ No	☐ Yes, # of slices: ☐ No
Detector Configuration:*			
Axial or Helical:*			
Pitch (for Axial):*			
Displayed CTDivol:*			
DLP:*			
Maximum mA:*			
Scan Time/Rotation:*			
mAs or effective mAs:*			
kVp:*			

*Mandatory

DIAGNOSTIC TECHNOLOGY CONSULTANTS, INC.
DTC
5930 Roe Avenue, Suite 201
Mission, Kansas 66205
913-236-6000 (Direct Line)
Toll Free: 800-753-4DTC (4382)
thull@dtcinc.com
statphysics@dtcinc.com
www.dtcinc.com

FETAL Dose Calculation Request
CT Examinations

Provide the information requested below for each Nuclear Medicine exam. If there are more than 3 procedures, submit both pages. Items in red are mandatory.
Upon completion of this form:

1) Save the file(s) to your computer.
2) **Upload** at https://dtcinc.com/form-upload-1.

Also please submit dose reports generated by the Nuclear Medicine equipment for each of the exams described on form.

Institutional Information:

Institution Name: Contact Number:
Contact Person: Contact Email:
Date Contacted:

Patient Information: (**DO NOT** submit the patient's name)

Medical Record #: Approximate Conception Date:
Patient's Weight: ☐ lbs ☐ kg Patient's Height: ft in

Equipment Information:

CT Scanner Used (brand, model, etc.): Room #:

Procedure Information: (Total number of procedures)

	CT Procedure #4	CT Procedure #5	CT Procedure #6
Name of Procedure:*			
Date of Procedure:*			
Anatomy Thickness:*			
Anatomical Scan Limits:*			
# of Slices:*			
Was the uterus involved?:*	☐ Yes, # of slices: ☐ No	☐ Yes, # of slices: ☐ No	☐ Yes, # of slices: ☐ No
Detector Configuration:*			
Axial or Helical:*			
Pitch (for Axial):*			
Displayed CTDivol:*. DLP:*			
Maximum mA:*			
Scan Time/Rotation:*			
mAs or effective mAs:*			
kVp:*			

***Mandatory**