

PATIENT Dose Calculation Request Nuclear Medicine 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 #:

Patient's Weight:

lbs

kg

Patient's Height

ft

in

Equipment Information:

Nuclear Medicine Equipment Used (brand, model, etc.):

Procedure Information: (Total number of procedures)

Nuclear Medicine Exam #1

Nuclear Medicine Exam #2

Nuclear Medicine Exam #3

Name of Procedure:*

Date of Procedure:*

Radiopharmaceutical:*

Dose:*

Additional Information:*

***Mandatory**

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Medical Record #:

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lbs

kg

Patient's Height

ft

in

Equipment Information:

Nuclear Medicine Equipment Used (brand, model, etc.):

Procedure Information: (Total number of procedures)

Nuclear Medicine Exam #4

Name of Procedure:*

Date of Procedure:*

Radiopharmaceutical:*

Dose:*

Additional Information:*

Nuclear Medicine Exam #5

Nuclear Medicine Exam #6

*Mandatory