

Institutional Information:

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

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.

Page 1 of 2

Institution Name: Contact Person: Date Contacted:	Contact Number: Contact Email:				
Patient Information: (DO NOT submit the patient's name)					
Medical Record #: Patient's Weight:	lbs kg	Patient's Height ft	in		
Equipment Informati	on:				
Nuclear Medicine Equipmen	t Used (brand, model, etc.)):			
Procedure Information	on: (Total number of proce	edures)			
	Nuclear Medicine	Nuclear Medicine	Nuclear Medicine		
	Exam #1	Exam #2	Exam #3		
Name of Procedure:*					
Date of Procedure:*					
Radiopharmaceutical:*					
Dose:*					
Additional Information:*					
*Mandatory					



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Institution Name:					
Contact Person: Date Contacted:	Contact Number: Contact Email:				
Patient Information: (DO NOT submit the patient's name)					
Medical Record #:					
Patient's Weight:	lbs kg	Patient's Height ft	in		
Equipment Informati	on:		***************************************		
Nuclear Medicine Equipment		c.):			
Drocoduro Informatio	No. (Table)		**************************************		
Procedure Information	III. (Total number of pro	cedures)			
	Nuclear Medicine	Nuclear Medicine	Nuclear Medicine		
	Exam #4	Exam #5	Exam #6		
Name of Procedure:*					
Date of Procedure:*					
Radiopharmaceutical:*					
Dose:*					
Additional Information:*					
*Mandatory					