CT SCANNER SHIELDING

Please provide all information requested:

Facility Name:____

Address ________________________ Room ________________________
________________________ Contact ________________________
________________________ Telephone ________________________
________________________ Fax ________________________
Email ____

CT Scanner: Manufacturer:___________________________________

Model:____

Maximum number of slices:______________

Patient Workload (Use maximum workload estimate for number of exams per week)

Procedure	Exams Per Week	kVp	mA	Rotation Time (sec)
Brain				
Chest				
Abd/Pelvis				
Other				

Room Layout: ¼" scale drawing with location of CT scanner.

For the following, mark all that apply. If there is occupied space above or below the room, please indicate the floor-to-floor (FTF) height and the thickness of concrete (if any) in the floor or ceiling.

- ☐ Single story building
- ☐ There is occupied space above room. FTF: ________ Conc.: _________
- ☐ There is occupied space below room. FTF: ________ Conc.: _________

Results To: ________________________ Bill To: ________________________
________________________ ________________________
________________________ ________________________
Attn: ________________________ P.O. # ________________________
Email: ________________________

***Payment is required prior to releasing the report.**
Reports are provided within 14 business days after all required information is received.

7525 SE Lake Road
Milwaukie, Oregon 97267
PH: 503-620-6617
FX: 503-684-5548
shielding@hpnw.com

Date Received: ______________
Job Number: ______________

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