HPNW
HEALTH PHYSICS NORTHWEST

PODIATRY X-RAY MACHINE SHIELDING

Please provide all information requested:

Facility Name:_____

Address:_____ Room Name/Number:_____

_____ Contact Name: _____

Phone:_____ Email:_____

X-ray Machine: Manufacturer_____

Model_____

Maximum kVp_____

Patient Workload (Use Maximum Projected Workload Figures)

Radiographic	No. of Exams/Week	No. of Exp./Exam	Average mAs/Exp.
Table Exams			

X-ray Beam Geometry

1. Percentage of exposures with lateral X-ray beam _____ _
2. Lateral X-ray beam direction _____

Patient Workload (Use Maximum Projected Workload Figures)

No. of Exams/Week	No. of Exp./Exam	Average mAs/Exp.

Room Layout: ¼" scale drawing with location of X-ray machine.

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 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
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FX: 503-684-5548
shielding@hpnw.com

Date Received: _____
Job Number: _____

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