Facility:_			Date:
		WORKSHEET FOR	DOSE ESTIMATES - CT
G p: fc	rilbert Health Platient's ID numb	nysics, Inc. Such requiver and organ for which ation or reference these	request must be submitted to the office of Krueger- est should be in the form of a letter and include the a dose is to be estimated. The letter must include the e worksheets. If these sheets are forwarded with the
		er # must accompany pt of the request.	this request. A written report will be provided within
P.O. #:			
SECTION	N A: PATIENT	INFORMATION:	
Patient Siz	ze:	Height: Weight:	
Patient ID	Number:		Patient Name:
SECTION	N B: EQUIPMI	ENT INFORMATION	í <b>:</b>
CT Manu	facturer		Model
	-		

Facility:	Date:	
WORKSHEET FOR DO	SE ESTIMATES – CT (CONTINUED	):
SECTION C: TECHNICAL DETAILS: <u>Exam #1</u>		
CT exam of	(e.g., abdomen + pelvis; pelvis; abd	lomen; head; etc.)
Repeated with contrast:NO	YES (add the details of the exam #	‡ 2 on a separate sheet)
Axial or Spiral	<del></del>	
kVp		
mAtime per rotation(e.g.	., 0.8 sec) <b>OR</b> mAs per rotation	(e.g., Siemens)
Number of Data Channels	$6.8 \times 2.5$ or $32 \times 0.5$ or $4 \times 2.5$ or etc.). eeded. This is NOT the reconstructed slication configuration from the images. You recalizer). If you are unable to provide the configuration from the provide the configuration.	e thickness (e.g., 5 mm need to identify the coll
Total beam coverage per rotation:	(e.g., 10 mm, 20 mm, 40 mm	per rotation)
If available: $\text{CTDI}_{\text{w}}$ or $\text{CTDI}_{\text{vol}}$ indicated on t	the panel (technique)	(mGy);
Table increment per rot (axial)(	mm) or Table speed per rot (spiral)	(mm/rot)
Scan Pitch (for spiral only)	(e.g., 1.375, or 1.2, or 1.35, or 0.9	etc.)
Table position at start	_(e.g., S 24)	
Table position at stop	_(e.g., I 450)	
If uterus in scan volume:		
Table position at top of uterus	_	
Table position at bottom of uterus		
Comments		
Signature of person completing this form:  Note: Insert additional sheets for other exam		

(KG Worksheets/doseestiCTnew.doc)