X-ray

_________________________________ Date: ____________________

WORKSHEET FOR DOSE ESTIMATES*

NOTE: To request a dose estimation, a written request must be submitted to the office of Krueger-Gilbert Health Physics, Inc. Such request should be in the form of a letter and include the patient's ID number and organ for which dose is to be estimated. The letter must include the above information or reference these worksheets. If these sheets are forwarded with the request, they must be signed.

A Purchase Order # must accompany this request. A written report will be provided within 7-10 day's of receipt of the request.

P.O. #:____________________

Exam: ____

Single or three phase unit?______________________________

Patient Size -- Chest AP:______________________________

Lateral:______________________________

Abdomen AP:______________________________

Lateral:______________________________

Patient ID Number:__________

FLUORO: N/A _____

Auto or Manual Mode?

I.I. Size:______________________________

Grid in or out?______________________________

kVp if set:______________________________

mA if set:______________________________

Beam projection:______________________________

Fluoro time for each beam projection:______________________________

SPOTS: N/A _____

Format? 105 mm __________

100 mm __________

4 on 1__________

Other (please specify) ______________________________

Auto or Manual Mode?______________________________

Set kVp at______________________________

Set mA at______________________________

Set time at______________________________

Photodensity set at ______________________________

Grid in or out?______________________________

Beam projection:______________________________

Total number of exposures for above beam projection______________________________

Additional projection:______________________________

Total number of exposures for above projection______________________________

Facility:______________________________ Date:______________

WORKSHEET FOR DOSE ESTIMATES

(continued)

OVERHEADS: Type of exam:______________________________

Number of films	Projection	Film Size	kVp	mAs*	SID

*If phototimed, must estimate mAs

Type of exam:______________________________

Number of films	Projection	Film Size	kVp	mAs*	SID

*If phototimed, must estimate mAs

Signature of person completing this form:______________________________