BONE DENSITY SHIELDING

Please provide all information requested:

Facility Name:____

Address:______________________________ Room Name/Number:______________________

______________________________________ Contact Name: ___________________________

Phone:________________________________ Email:__________________________________

Bone Density Machine: Manufacturer:________________Model:__________________

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

Exams Per Week	Scan Time (sec.)

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
PH: 503-620-6617
FX: 503-684-5548
shielding@hpnw.com

Date Received: ______________
Job Number: ______________

Revised 3/31/2021