CATH LAB 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)

No. of exams per week	
Number of digital runs per exam	
Length of each digital run (sec)	
Average digital pulse sequence (frames per second)	
Average digital pulse width (seconds)	
Length of fluoroscopic exam (minutes)	

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