RADIOGRAPHIC/FLUOROSCOPIC X-RAY MACHINE SHIELDING

Please provide all information requested:

Facility Name:____

Address ______________________ Room ______________________
______________________ Contact ______________________
______________________ Telephone ______________________
______________________ Fax ______________________
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			
Chest Exams			
Other Lateral Exams			
Fluoroscopic	No. of Exams/Week	Fluoro Time/Exam	

Room Layout: ¼" scale drawing with location of X-ray machine and wall or upright bucky.

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: ____________

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