HPNW
HEALTH PHYSICS NORTHWEST

NUCLEAR MEDICINE SPECT/CT SHIELDING

Please provide all information requested:

Facility Name: _____

Address _____ Room _____
_____ Contact _____
_____ Telephone _____
_____ Fax _____
Email _____

SPECT Unit: Manufacturer:_____ Model:_____

SPECT Patient Workload

Radioactive material used _____
Average Administered Dose _____ mCi Average scan time _____

CT Techniques (if applicable)

Procedure	Exams Per Week	kVp	mA	Rotation Time (sec)
Brain				
Chest				

Room Layout: ¼" scale drawing with location of gamma camera.

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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