Basic X-ray, CT or Nuc Med Information Needed to Produce Shielding Plan  (3 pages)

Please note that we need 1 request per room that needs to be shielded.

1. Facility Name, Address, City, Zip of the new room(s). Room numbers also REQUIRED on plans sent.

   Facility Name_________________________________________ Room Number: _________
   Address ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________ (full street address including zip)

   Project name: ____________________________________________
   (examples: Cath Lab Rm1, CT 2, or New Endoscopy Suite, etc)

2. Name and email of individual who will be acting as the X-ray registrant for the facility. This individual from the facility will need to submit the shielding plan to MDH when it is completed. This is typically the radiology manager, or lead x-ray tech if a manager isn’t available.

   Name_________________________________________ Email______________________

3. Purpose of Shielding Plan request?
   [ ] New Room construction
   [ ] Change of equipment use in existing room (i.e. adding upright bucky to general rad room, etc)
   [ ] Remodel of existing room (change of 1 or more walls, windows or doors)

4. What is the General category of Use for the Room?
   [ ] Radiographic room       [ ] Radiographic/Fluoroscopic room
   [ ] Dedicated Chest room    [ ] CT suite
   [ ] C-arm procedure room    [ ] Veterinary radiographic
   [ ] Dental Panoramic or CBCT [ ] SPECT room
   [ ] PET suite              [ ] Other __________________________
   [ ] Specials room (including IR, CV, EP, dedicated fluoro, etc)

5. If an X-ray room, does the room have an upright wall bucky? [ ] Yes [ ] No
   If Yes is checked, the location MUST be marked on the room layout or this may delay the planning process.

6. Date by which you are requesting to have the completed shielding plan. Please note that standard turnaround time for a plan is 4-6 weeks due to existing schedules. The clock starts once ALL information requested on this form has been submitted to us. Also note that State agencies generally request 30 days for review of plan once submitted. __________________________ (requested date for plan). If you need the plan in less than 4 weeks, please send an email separately to request RUSH processing.
7. Estimated first patient use date. _____________________________

8. We need a scale drawing of building layout showing the proposed room. Plan North or Actual North MUST be marked on the drawing. **IMPORTANT: This drawing needs to show both the room being shielded as well as the surrounding rooms.** The x-ray vendor drawing often does not contain this information, so you will probably need a full layout from facilities or building management.

   [ ] PDF drawing of room layout included with this form  
   (we do NOT have ability to review CAD drawings)  
   [ ] North or Plan North must be labeled on the drawing  
   [ ] Surrounding rooms, corridors and outside areas clearly labeled

9. We need a scale drawing of room showing location of equipment (including table, upright wall bucky, etc). This should be a close-up of just the room if possible, typically supplied by the x-ray vendor.

   [ ] PDF drawing showing equipment layout included in email with this form

10. If there are any outside wall(s), what is their construction? If brick or masonry, thickness is required for possible elimination of lead on these outside walls.

   __________________________________________________________
   __________________________________________________________

11. If outside walls are at ground level, please send drawing showing outside features to include sidewalks, parking lots, and landscaping.

   [ ] PDF drawing showing outside features included in email with this form

12. Is the space above and/or below occupied? If it is, what is the construction of the floor/ceiling? If concrete, what is the minimum thickness? And what is the use of the space?
   a. Occupied above?  Yes [ ]  No [ ]  If yes, what is the floor to floor height in feet? _______ ft
   b. Occupied below?  Yes [ ]  No [ ]  If yes, what is the floor to floor height in feet? _______ ft  
   (if not occupied above or below, may skip c-f)
   c. Ceiling material?  Concrete [ ]  Thickness ___ inches  Other [ ] ____________
   d. Floor material?  Concrete [ ]  Thickness ___ inches  Other [ ] ____________
   e. Use of space above _________________________ (i.e. clinic, office, etc)  
   f. Use of space below _________________________ (i.e. clinic, office, etc)
13. Patient exam information: (please note that we may calculate the plan for a higher workload to be conservative)
   If the room is open for multiple shifts, only estimate the maximum number of patients per 40 hour shift.
   
a. How many patients per week (40 hr shift) will be imaged at MAX CAPACITY? ________________
   (think years from now, not current)
   
b. What type of studies? __________________________________________________________
   
c. Percent of exams for upright bucky? ________%  [ ] N/A

14. Equipment information:
   
a. Installation vendor ____________________________
   
b. Equipment make ____________________________ (i.e. GE, Siemens, Toshiba, Philips, etc)
   
c. Equipment model ____________________________

15. What is the maximum kVp and mA of the xray generator?
   
   Max kVp ________  max mA __________  [ ] N/A

16. Contact person information for patient use information. (Name, email, phone)
   
   Name:____________________________
   Email:____________________________
   Phone:____________________________

17. Contact person with building questions. (Name, email, phone)
   
   Name:____________________________
   Email:____________________________
   Phone:____________________________

18. Who will be responsible for the Invoice? The facility or the architectural firm or other? Please give email
    address to send invoice to, as well as PO if available. If PO is not available, an email indicating approval
    of the estimate fee will be required before proceeding.
   
   Name:____________________________
   Email:____________________________
   Phone:____________________________