

Radiation Shielding Design Request Form

Cath Lab Room

Contact Information

Facility Name _____	Room ID or Number _____
Street Address _____	State _____
City _____	Zip Code _____
First Name _____	Last Name _____
Title _____	Company _____
Email _____	Phone _____

Equipment Information and Workload

Manufacturer _____	Model _____
Estimated Maximum # of Fluoroscopic Patients Per Week _____	Maximum kVp _____
Average Fluoroscopy Time Per Exam _____	

Construction Information

Construction Type	<input type="checkbox"/> New Construction	Is There a Previous or Existing	<input type="checkbox"/> Yes
	<input type="checkbox"/> Remodel of Existing Building	Shielding Design For This Space?	<input type="checkbox"/> No
	<input type="checkbox"/> Remodel of Existing Shielded Rm		
	<input type="checkbox"/> Equipment Replacement	Is This a Multiple Story Building?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Other _____	*If YES, please answer the additional questions below.	

Which Floor Is the Room On? _____	What Is The Floor to Floor Height? _____
What Is The Floor / Ceiling Building Material? _____	
What Is The Floor / Ceiling Building Thickness? _____	
Are There Occupied Spaces Above or Below? <input type="checkbox"/> Above <input type="checkbox"/> Below <input type="checkbox"/> Both	
What Is Above or Below? _____	

Describe the areas that are on the opposite sides of each wall (ie: office space, work areas, hallways, bathrooms, etc.)

All walls are assumed to contain standard gypsum wallboard with a total thickness of 1.25". If additional materials are known to be present, please list known compositions and thicknesses (ie: 0.79 mm of lead, 8 inches of concrete).

Comments

Please include a scale (1/4") drawing of the room in PDF format. The drawing should include the placement and orientation of equipment as well as surrounding spaces.

Please submit this form to info@olympichp.com. For questions, call 253.254.6988.

