

**Attachment 1: Shielding Design Procedure Guidelines, ORS GL-6**

**Shielding Design Request - Information Form**

|            |
|------------|
| Project ID |
|------------|

|  |  |      |
|--|--|------|
| Facility and Room ID   | Room Function (e.g. Radiographic, Rad- Fluoro, Cath Lab, Procedure Room, etc.) | Date |
| Facility: Building name and Address, Architectural Room Number and Floor |  |      |

**Room Floor**

|  |  |   |
|--|--|---|
| Below RM Use Area<br><input type="checkbox"/> Earth <input type="checkbox"/> Occupied Space  | Occupancy description (e.g. Office (full), corridor, toilet) | Slab to Slab Distance Below (typical 14 to 16 ft) |
| Floor Construction<br><input type="checkbox"/> Normal Density Concrete <input type="checkbox"/> Light-Weight Concrete <input type="checkbox"/> Other: (please specify) |  |   |
| Minimum Concrete Thickness   | Thickness of Steel Deck (gauge)                              | Other Material, (e.g. Wood)                       |

**Room Ceiling**

|  |  |                             |
|--|--|-----------------------------|
| Above RM Use Area<br><input type="checkbox"/> Roof <input type="checkbox"/> Occupied Space   | Occupancy (e.g. Office (full), corridor, toilet) | Slab to Slab Distance Above |
| Floor Above Construction<br><input type="checkbox"/> Normal Density Concrete <input type="checkbox"/> Light-Weight Concrete <input type="checkbox"/> Other: (please specify) |  |                             |
| Minimum Concrete Thickness   | Thickness of Steel Deck (gauge)                  | Other Material, (e.g. Wood) |

**Room Walls**

|   |
|---|
| Describe specific composition and thickness of walls if constructed of material other than gypsum drywall or Sheet Rock (e.g., concrete, brick, concrete block, etc.) |
|---|

**Equipment Mfg. Model and Room Design**

|   |  |   |
|---|--|---|
| Equipment Vendor (e.g. Philips, GE, Siemens etc.) | Equipment Type (e.g. Gen Rad, RF, include model) | Type of Construction<br><input type="checkbox"/> Room Remodel <input type="checkbox"/> New Construction |
| Project Manager                                   | Department                                       | Imaging Equipment Specialist / Vendor Contact   |

**Shielding Design and Functional Details**

Room workload, **(1) Radiographic:** Indicate number and type of exams per week and number of views for each (e.g. 30 extremities, 2 views each, 15 chests, PA and LAT, 2 views 25 Abdomen, 4 views. Include technique, kVp, mAs is possible) and/ or **(2) Fluoroscopic:** mA minutes per week for low, medium or high use room, (e.g. Radiographic Low 250, medium 500, high 1000, Fluoro: Low 500, medium 1000, high 2000) **(3)** Indicate if **CT or Mammography** request.

| Radiographic Exam descriptions: Exam Type | Number of Views | kVp | mAs |
|---|-----------------|-----|-----|
|   |                 |     |     |
|   |                 |     |     |
|   |                 |     |     |
|   |                 |     |     |
|   |                 |     |     |

| Fluoroscopic Exam descriptions: Study | Estimated number per year | Estimate time/study |
|---------------------------------------|---------------------------|---------------------|
|                                       |                           |                     |
|                                       |                           |                     |
|                                       |                           |                     |
|                                       |                           |                     |
|                                       |                           |                     |

CT or Mammography: