F-PR-FPR.002.(ev) SAMPLE QUESTIONNAIRE FOR THE REQUESTOR

I,.....(name), born.....(dd/mm/yy) consent to giving a blood sample for the purpose of estimating chromosome aberrations induced by exposure to ionizing radiation

.....
Signature

Blood sample taken by:

Laboratory name

Laboratory address

Telephone: Fax:

E-mail:

Blood sample taken: date (dd/mm/yy) and time (hh:mm)

EXPOSURE DATA

Radiation worker yes ☐ or NO ☐

1. Date and time of overexposure: (dd/mm/yy) (hh:mm)

2. Place: Company:

3. Brief description of overexposure:

4.

Whole body exposure	Partial body exposure	Internal contamination
YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Dose value	Part of body	Nuclide
	Dose value	Dose value

How was this dose value obtained:

5. Type of radiation:

X-ray Energy?

γ Origin?
α Origin?
Neutrons Origin? Energy?
Electrons Origin? Energy?

PATIENT DATA

1. Previous exposure through medical practice:

Radiation Therapy Date, part of the body

X ray diagnoses Date, part of the body

Nuclear medicine Date, part of the body

2. Illness within the last 4 weeks before taking the blood sample:

3. Intake of medication: SI ☐ NO ☐

Name of medication:

Dose Duration:

4. Smoker NO ☐ yes ☐ number cigarettes / day:

5. Other diseases:

HIV Hepatitis

RESULTS OF CHROMOSOMAL ANALYSES TO BE SENT TO:

Name:

Address:

Telephone: