St. Teresa's Hospital
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Online Booking
網上預約

Appointment Date:
Time:

Ⓐ TYPE OF MRI SCAN REQUESTED: (PLEASE ✓ APPROPRIATE ITEMS)

Head & Neck

1. ☐ Brain
2. ☐ MRA of Brain
3. ☐ CE-MRA# of Brain & Neck
4. ☐ Stroke Assessment (1+2+3)
5. ☐ Stroke Assessment with contrast Brain
6. ☐ Brain Spectroscopy
7. ☐ Brain Perfusion
8. ☐ Brain Perfusion (with Diamox) (*Please provide latest creatinine)
9. ☐ Pituitary
10. ☐ Orbits
11. ☐ Paranasal Sinuses
12. ☐ Nasopharynx
13. ☐ Hypopharynx
14. ☐ Soft Tissue of Neck

CE-MRA = Contrast Enhanced MRA

Trunk

15. ☐ Thorax
16. ☐ MRCP (Cholangiogram Plain only)
17. ☐ Upper Abdomen (general)
18. ☐ Pancreas & MRCP
19. ☐ Pelvis
    - ☐ Rectum
20. ☐ Prostate
    - ☐ Non-contrast (Standard)
    - ☐ Contrast (Multiparametric)
    - ☐ Fusion for navigation
21. ☐ Breasts

Spine

22. ☐ Cervical Spine
23. ☐ Thoracic Spine
24. ☐ Lumbar Spine
25. ☐ Sacrococcygeal Spine
26. ☐ SI-joints

Extremities

27. ☐ Shoulder (☐R☐L)
28. ☐ Arm/Humerus (☐R☐L)
29. ☐ Elbow (☐R☐L)
30. ☐ Forearm (☐R☐L)
31. ☐ Wrist (☐R☐L)
32. ☐ Palm (☐R☐L)
33. ☐ Hip (☐R☐L)
34. ☐ Thigh / Femur (☐R☐L)
35. ☐ Knee (☐R☐L)
36. ☐ Calf/Tibia&Fibula (☐R☐L)
37. ☐ Ankle & Hindfoot (☐R☐L)
38. ☐ Forefoot & Midfoot (☐R☐L)
39. ☐ Arthrogram of _____ (☐R☐L)

High Resolution Small Parts

40. ☐ _______ Finger (☐R☐L)
41. ☐ _______ Toe (☐R☐L)
42. ☐ T-M Joints

Contrast Enhanced MR Angiogram (CE-MRA#)

43. ☐ Renal / Abdominal CE-MRA
44. ☐ Peripheral CE-MRA (*Please provide latest creatinine)
45. ☐ Pulmonary CE-MRA
46. ☐ Thoracic Aorta CE-MRA
47. ☐ Whole Body CE-MRA (*Please provide latest creatinine)

Cardiac (* Please provide latest creatinine)

48. ☐ Basic Anatomy & Function
49. ☐ Viability
50. ☐ Stress (Adenosine) Perfusion & Viability
51. ☐ Full Ischaemic Heart Assessment (48+49+50)
52. ☐ + CT Coronary Angiogram
53. ☐ Cardiomyopathy Assessment
54. ☐ Volume / Flow Assessment / Flow Quantification

Others

55. ☐ Hypertension Assessment (Renal MRA, Kidneys & Adrenals)
56. ☐ Whole Body Screening
57. ☐ Metal Artifact Reduction
58. ☐ ____________________

Ⓑ Contrast Enhancement:
59. ☐ NON-CONTRAST
60. ☐ NON-CONTRAST & CONTRAST
61. ☐ TO BE DECIDED BY RADIOLOGIST

Ⓒ MEDICAL & PHYSICAL INFORMATION: (PLEASE ✓ APPROPRIATE ITEMS)

eGFR __________
IV Contrast ________ %
Dr. __________

☐No ☐Yes *Allergy to Gadolinium (MR Contrast)*
if yes, please prescribe steroid premedication
(adult regime: Oral prednisolone 40mg 12 hr. & 2 hr. before contrast MR)

☐No ☐Yes **Renal Impairment**
latest Creatinine __________ *Date:* __________
(within 2 weeks)

☐No ☐Yes **Cardiac pacemaker** ☐No ☐Yes **Ocular metallic foreign body** ☐No ☐Yes **Middle ear prosthesis** ☐No ☐Yes **Neuro-stimulators**

☐No ☐Yes **Metallic implant** ________ ☐No ☐Yes **Aneurysm clips** ________ ☐No ☐Yes **Patient is pregnant LMP** ________ ☐ **Menopause** ________

☐No ☐Yes **Hypertension** ________ ☐No ☐Yes **Diabetes Mellitus** ________ ☐No ☐Yes **Heart disease** ________ Body Height ______ cm

☐No ☐Yes **Previous operation** ____________________ Body Weight ______ Kg.

Ⓓ CLINICAL INFORMATION: (HISTORY & PHYSICAL SIGNS & SYMPTOMS & LAB. RESULTS)

PROVISIONAL CLINICAL DIAGNOSIS:

Official use:

take Hx: __________

'er 1: __________ ☐ consent checked

'er 2: __________

Own films __________

____

Image print ________

Printed old films ______

Ⓔ REFERRING DOCTOR: ____________________ (code: ________) Signed: __________

Tel.: __________ Address: ____________________ Date: __________

Please stick label if available

Patient's Name: ____________________

____

Sex/Age: ________ D.O.B.: ________ HKID: ________

Hosp./Hosp.No.: ________ Ward/Rm. No.: ________

MRI SCAN
磁力共振掃描
Requisition form

MR-SCAN-091 Revised Jan 2024