St. Teresa's Hospital
Scanning Department
(CT, MR, NM, PET-CT, PET-MR)
B1 Floor, Main Block, 327 Prince Edward Road, Kowloon.
Tel.: (852) 2715 8660 Fax: (852) 2762 2718
E-mail: booking@sthscan.com

聖德肋撒醫院
掃描部
香港九龍太子道327號醫院大樓地庫一層
電話：(852) 2715 8660 傳真：(852) 2762 2718
電郵：booking@sthscan.com

Online Booking
網上預約

Ⓐ TYPE OF PET-MR SCAN REQUESTED: (PLEASE ✓ APPROPRIATE ITEMS)

Appointment Date:
Time:

☐ **F-18 FDG Whole Body Trunk PET-MR (non-contrast)**
(vertex to upper thigh) with complementary low dose screening CT thorax
☐ add comprehensive whole body MRI (non-contrast)

☐ **PSMA Whole Body Trunk PET-MR (non-contrast)**
(vertex to upper thigh) with complementary low dose screening CT thorax

\+
☐ MRI of Brain
☐ MRI of NP/Neck
☐ MRI of Breast
☐ MRI of Liver/Upper Abdomen
☐ MRI of Pelvis
☐ MRI of Abdomen and Pelvis
☐ MRI of Prostate *(Referring Doctor please prescribe bowel preparation e.g. Oral Dulcolax 10mg on the night before examination)*

\+
☐ non-contrast
☐ non-contrast & contrast
☐ optional contrast

☐ **F-18 FDG PET-MR brain**
☐ non-contrast
☐ non-contrast & contrast
☐ optional contrast

☐ add-on Perfusion
☐ add-on Spectroscopy
☐ add-on Brain MRA

☐ **Dementia package**
(F-18 FDG + C-11 PiB)

☐ **Parkinson's disease package**
(F-18 FDG + F-18 FDOPA)

☐ **C-11 Methionine PET-MR brain**

Ⓑ 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.: _____

PET-MR SCAN
正電子及磁力共振掃描
Requisition form