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
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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

Appointment Date:
Time:

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

Neuro
① ☐ Brain
② ☐ Cerebral Angiogram
③ ☐ Brain + Perfusion
④ ☐ Brain + Diamox Perfusion Study
⑤ ☐ Neck Angiogram

Head & Neck
⑥ ☐ Orbits
⑦ ☐ Paranasal Sinuses
⑧ ☐ Temporal Bone
⑨ ☐ Facial Bone
⑩ ☐ Neck

Body
⑪ ☐ Thorax (HRCT included)
⑫ ☐ Pulmonary Angiogram
⑬ ☐ Low dose screening thorax (non-contrast)
⑭ ☐ Whole Abdomen (from diaphragm to symphysis pubis)
⑮ ☐ Upper Abdomen (from diaphragm to iliac crest)
⑯ ☐ Pelvis (from iliac crest to symphysis pubis)
⑰ ☐ Appendix
⑱ ☐ CT Urogram

Cardiovascular
⑲ ☐ Coronary Angiogram
(Calcium Score included)

Musculoskeletal
⑳ ☐ Spine _____
Specify levels

Interventional
㉑ ☐ CT guided _____
Is patient on antiplatelet / anticoagulant ☐No
If ☐Yes, name of the drug _____
Allowing to withhold the drug or not ☐No☐Yes

Others
㉒ ☐ _____

Ⓑ Contrast Enhancement: ㉔ ☐ NON-CONTRAST ㉕ ☐ OPTIONAL ㉖ ☐ CONTRAST ONLY ㉗ ☐ NON-CONTRAST & CONTRAST

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

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

☐*No* ☐*Yes* ***Renal Impairment***
☐*No* ☐*Yes* ***over 60 years old***
☐*No* ☐*Yes* ***Diabetes Mellitus*** _____

eGFR _____ IV Contrast _____ % Dr. _____
if yes, for contrast CT please provide
latest Creatinine _____ ***Date:*** _____
within 2 weeks

☐No ☐Yes **Patient is pregnant** **LMP** _____ ☐ **Menopause** _____

☐*No* ☐*Yes* ***on Metformin***

☐No ☐Yes Hypertension _____ ☐No ☐Yes Heart disease _____ Body Weight _____Kg.

☐No ☐Yes Previous operation _____

Ⓓ 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 or use block letter

Patient's Name: _____

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

Hosp./Hosp. No.: _____ Ward/Rm. No.: _____

CT SCAN
電腦掃描
Requisition form