St. Teresa's Hospital 聖德肋撒醫院

Scanning Department 掃描部

(CT, MR, NM, PET-CT, PET-MR)
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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 (Biparametric)
☐ 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 ☐ Basic Anatomy, Function & 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 or use block letter

Patient's Name: _____

_____

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

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

☐ Discharged Patient's Tel. _____

MRI SCAN

磁力共振掃描

Requisition form

MR-SCAN-091 Revised Nov 2025