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

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

Appointment Date: Time:

Whole Body

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

☐ FDG 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)

☐ add comprehensive whole body MRI (non-contrast)

Brain

☐ FDG PET-MR brain + MRI of brain
☐ Parkinson's disease package (FDG+ FDOPA) PET-MR brain with non-contrast MRI of brain
☐ FET PET-MR brain + MRI of brain

\+

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

Amyloid Brain Scan (Neuraceq®)
☐ Florbetaben (FBB) PET-MR brain + MRI of brain

\+ ☐ add-on FDG PET-MR brain

Ⓑ **Contrast Enhancement:** ☐ NON-CONTRAST ☐ NON-CONTRAST & CONTRAST ☐ 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. _____

PET-MR SCAN

正電子及磁力共振掃描
Requisition form

MR-SCAN-093 Revised Nov 2025