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:

(A) 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 (plain only) (Cholangio-pancreatogram)
(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 (plain only)
(49) ☐ Basic Anatomy, Function & Viability
(50) ☐ Stress (Adenosine) Perfusion & Viability
(51) ☐ Full Ischaemic Heart Assessment (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) ☐ _____

(B) CONTRAST ENHANCEMENT: (59) ☐NON-CONTRAST (60) ☐NON-CONTRAST & CONTRAST (61) ☐TO BE DECIDED BY RADIOLOGIST

(C) 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.

(D) 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 _____

(E) 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