

St. Teresa's Hospital

Scanning Department

(CT, MR, NM, PET-CT, PET-MR)
B1 Floor, Main Block, 327 Prince Edward Road, Kowloon.
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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
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Online Booking
網上預約

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

Appointment Date:
Time:

Neuro

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

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

Head & Neck

- ⑥ Orbits
⑦ Paranasal Sinuses
⑧ Temporal Bone
⑨ Facial Bone
⑩ Neck

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 _____

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

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

eGFR _____ IV Contrast _____ % Dr. _____

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 Diabetes Mellitus

No Yes on Metformin

if yes, for contrast CT please provide
Latest Creatinine _____ Date: _____
within 2 weeks

No Yes Patient is pregnant LMP _____ Menopause _____

No Yes Hypertension _____ No Yes Heart disease _____

Body Weight _____ kg.

No Yes Previous operation _____

D CLINICAL INFORMATION: (HISTORY & PHYSICAL SIGNS & SYMPTOMS & LAB. RESULTS)

Official use:

take Hx: _____

'er 1: _____ consent checked

'er 2: _____

Own films _____

Image print _____

Printed old films _____

PROVISIONAL CLINICAL DIAGNOSIS:

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.: _____

Patient's Tel.: _____

Contact person: _____ Tel.: _____

Discharged

CT SCAN

電腦掃描

Requisition form