

St. Teresa's Hospital

Scanning Department

(CT, MR, NM, PET-CT, PET-MR)
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聖德肋撒醫院

掃描部

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Online Booking
網上預約

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

Appointment Date:
Time:

Head & Neck	Trunk	Extremities	Contrast Enhanced MR Angiogram (CE-MRA#)
(1) <input type="checkbox"/> Brain	(15) <input type="checkbox"/> Thorax	(27) <input type="checkbox"/> Shoulder (□R □L)	(43) <input type="checkbox"/> Renal / Abdominal CE-MRA
(2) <input type="checkbox"/> MRA of Brain	(16) <input type="checkbox"/> MRCP (plain only) (Cholangio-pancreatogram)	(28) <input type="checkbox"/> Arm/Humerus (□R □L)	(44) <input type="checkbox"/> Peripheral CE-MRA (*Please provide latest creatinine)
(3) <input type="checkbox"/> CE-MRA# of Brain & Neck	(17) <input type="checkbox"/> Upper Abdomen (general)	(29) <input type="checkbox"/> Elbow (□R □L)	(45) <input type="checkbox"/> Pulmonary CE-MRA
(4) <input type="checkbox"/> Stroke Assessment (1) + (2) + (3)	(18) <input type="checkbox"/> Pancreas & MRCP	(30) <input type="checkbox"/> Forearm (□R □L)	(46) <input type="checkbox"/> Thoracic Aorta CE-MRA
(5) <input type="checkbox"/> Stroke Assessment with contrast Brain	(19) <input type="checkbox"/> Pelvis <input type="checkbox"/> Rectum	(31) <input type="checkbox"/> Wrist (□R □L)	(47) <input type="checkbox"/> Whole Body CE-MRA (*Please provide latest creatinine)
(6) <input type="checkbox"/> Brain Spectroscopy	(20) <input type="checkbox"/> Prostate <input type="checkbox"/> Non-contrast (Biparametric) <input type="checkbox"/> Contrast (Multiparametric) <input type="checkbox"/> Fusion for navigation	(32) <input type="checkbox"/> Palm (□R □L)	Cardiac (* Please provide latest creatinine)
(7) <input type="checkbox"/> Brain Perfusion		(33) <input type="checkbox"/> Hip (□R □L)	(48) <input type="checkbox"/> Basic Anatomy & Function (plain only)
(8) <input type="checkbox"/> Brain Perfusion (with Diamox) (*Please provide latest creatinine)		(34) <input type="checkbox"/> Thigh/Femur (□R □L)	(49) <input type="checkbox"/> Basic Anatomy, Function & Viability
(9) <input type="checkbox"/> Pituitary		(35) <input type="checkbox"/> Knee (□R □L)	(50) <input type="checkbox"/> Stress (Adenosine) Perfusion & Viability
(10) <input type="checkbox"/> Orbits	(21) <input type="checkbox"/> Breasts	(36) <input type="checkbox"/> Calf / Tibia & Fibula (□R □L)	(51) <input type="checkbox"/> Full Ischaemic Heart Assessment (49) + (50)
(11) <input type="checkbox"/> Paranasal Sinuses	Spine	(37) <input type="checkbox"/> Ankle & Hindfoot (□R □L)	(52) <input type="checkbox"/> + CT Coronary Angiogram
(12) <input type="checkbox"/> Nasopharynx	(22) <input type="checkbox"/> Cervical Spine	(38) <input type="checkbox"/> Forefoot & Midfoot (□R □L)	(53) <input type="checkbox"/> Cardiomyopathy Assessment
(13) <input type="checkbox"/> Hypopharynx	(23) <input type="checkbox"/> Thoracic Spine	(39) <input type="checkbox"/> Arthrogram of _____ (□R □L)	(54) <input type="checkbox"/> Volume / Flow Assessment / Flow Quantification
(14) <input type="checkbox"/> Soft Tissue of Neck	(24) <input type="checkbox"/> Lumbar Spine	High Resolution Small Parts	Others
	(25) <input type="checkbox"/> Sacrococcygeal Spine	(40) <input type="checkbox"/> _____ Finger (□R □L)	(55) <input type="checkbox"/> Hypertension Assessment (Renal MRA, Kidneys & Adrenals)
	(26) <input type="checkbox"/> SI-joints	(41) <input type="checkbox"/> _____ Toe (□R □L)	(56) <input type="checkbox"/> Whole Body Screening
		(42) <input type="checkbox"/> T-M Joints	(57) <input type="checkbox"/> Metal Artefact Reduction
			(58) <input type="checkbox"/> _____

#CE-MRA = Contrast Enhanced MRA

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

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

<input type="checkbox"/> No <input type="checkbox"/> Yes Allergy to Gadolinium (MR Contrast) if yes, please prescribe steroid premedication (adult regime: Oral prednisolone 40mg 12 hr. & 2 hr. before contrast MR)	<input type="checkbox"/> No <input type="checkbox"/> Yes Renal Impairment Latest Creatinine _____ Date: _____ (within 2 weeks)	eGFR _____ IV Contrast _____ % Dr. _____	
<input type="checkbox"/> No <input type="checkbox"/> Yes Cardiac pacemaker	<input type="checkbox"/> No <input type="checkbox"/> Yes Ocular metallic foreign body	<input type="checkbox"/> No <input type="checkbox"/> Yes Middle ear prosthesis	<input type="checkbox"/> No <input type="checkbox"/> Yes Neuro-stimulators
<input type="checkbox"/> No <input type="checkbox"/> Yes Metallic implant _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Aneurysm clips _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Patient is pregnant LMP _____	<input type="checkbox"/> Menopause _____
<input type="checkbox"/> No <input type="checkbox"/> Yes Hypertension _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes Mellitus _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Heart disease _____	Body Height _____ cm
<input type="checkbox"/> No <input type="checkbox"/> Yes Previous operation _____			Body Weight _____ kg.

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

PROVISIONAL CLINICAL DIAGNOSIS: _____

(E) REFERRING DOCTOR: _____ (code: _____) Signed: _____

Tel.: _____ Address: _____ Date: _____

Official use:
take Hx: _____
consent
'er 1: _____ checked
'er 2: _____
Own films _____
Image print _____
Printed old films _____

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

MRI SCAN

磁力共振掃描
Requisition form