

St. Teresa's Hospital

Scanning Department

(CT, MR, NM, PET-CT, PET-MR)
 B1 Floor, Main Block, 327 Prince Edward Road, Kowloon.
 Tel.: (852) 2715 8660 Fax: (852) 2762 2718
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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
 電話: (852) 2715 8660 傳真: (852) 2762 2718
 電郵: booking@sthscan.com



Online Booking
 網上預約

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

Appointment Date:
 Time:

- | | | |
|--|---|---|
| <input type="checkbox"/> F-18 FDG

<input type="checkbox"/> PSMA

<input type="checkbox"/> Ga-68 Dotatate

<input type="checkbox"/> F-18 FDG +
C-11 Acetate | } | <input type="checkbox"/> Whole Body Trunk (skull base to upper thigh)
(non-contrast CT)
<input type="checkbox"/> Whole Body Trunk (skull base to upper thigh)
(optional contrast)
<input type="checkbox"/> Whole Body Trunk (skull base to upper thigh)
+ Contrast CT of (with CT report):
<input type="checkbox"/> Brain (with PET Brain)
<input type="checkbox"/> Neck
<input type="checkbox"/> Thorax
<input type="checkbox"/> Upper Abdomen (from diaphragm to iliac crest)
<input type="checkbox"/> Pelvis (from iliac crest to symphysis pubis)
<input type="checkbox"/> Others: _____ |
|--|---|---|

Others

- F-18 FDG Brain
- F-18 Cardiac - Viability
- Amyloid Brain Scan (Neuraceq®)
- Florbetaben (FBB) PET-CT brain
- + add-on FDG PET-CT brain

Ⓑ **MEDICAL & PHYSICAL INFORMATION:** (PLEASE ✓ APPROPRIATE ITEMS)

- | | |
|--|---|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Allergy to Iodinated Contrast
if yes, please prescribe steroid premedication
(adult regime: Oral prednisolone 40mg 12 hr. & 2hr. before contrast CT) | <input type="checkbox"/> No <input type="checkbox"/> Yes Renal Impairment

<input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes Mellitus _____
<input type="checkbox"/> No <input type="checkbox"/> Yes on Metformin |
| <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 Heart disease _____ |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Previous operation _____ | |

eGFR _____ IV Contrast _____ % Dr. _____

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

Body Weight _____ kg.

Ⓒ **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: _____

Ⓓ **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

PET-CT SCAN

正電子電腦掃描
 Requisition form