

St. Teresa's Hospital

Scanning Department

(CT, MR, NM, PET-CT, PET-MR Scan)

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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

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 Carotid Angiogram

Head & Neck

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

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
- ⑲ CT Colonoscopy

Interventional

- ⑳ CT guided _____

Cardiovascular

- ㉑ Coronary Angiogram (Calcium Score included)

Musculoskeletal

- ㉒ Spine _____
Specify levels

Others

- ㉓ _____

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

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

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 over 60 years old

No Yes Diabetes Mellitus

No Yes Patient is pregnant LMP: _____

Menopause _____

No Yes on Metformin (if yes, withhold Metformin for 48 hrs from date of contrast CT)

No Yes Heart disease _____

No Yes Hypertension _____

Body Weight _____ Kg.

No Yes Previous operation _____

eGFR _____ IV Contrast _____ % Dr. _____

if yes, for contrast CT please provide

latest Creatinine _____ Date: _____
within 2 weeks

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

Official use:

take Hx: _____

Order 1: _____ consent checked

Order 2: _____

Own films _____

Image print _____

Printed old films _____

PROVISIONAL CLINICAL DIAGNOSIS IF ANY:

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.: _____

CT SCAN

電腦掃描

Requisition form