St. Teresa's Hospital
Scanning Department
(CT, MR, NM, PET-CT, PET-MR Scan)

B1 Floor, Main Block, 327 Prince Edward Road, Kowloon.
Tel.: (852) 2715 8660 Fax: (852) 2762 2718

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

Appointment Date: Time:

Ⓐ 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)
- 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 (Cholangiogram Plain only)
- ⑰ ☐ Upper Abdomen
- ⑱ ☐ Pelvis
- ⑲ ☐ Prostate
  - ☐ Routine
  - ☐ Multiparametric study
  - ☐ Fusion for navigation
- ⑳ ☐ Breasts

Spine
- ㉑ ☐ Cervical Spine
- ㉒ ☐ Thoracic Spine
- ㉓ ☐ Lumbar Spine
- ㉔ ☐ Sacrococcygeal Spine
- ㉕ ☐ SI-joints

Extremities
- ㉖ ☐ Shoulder (☐R ☐L)
- ㉗ ☐ Arm/Humerus (☐R ☐L)
- ㉘ ☐ Elbow (☐R ☐L)
- ㉙ ☐ Forearm (☐R ☐L)
- ㉚ ☐ Wrist (☐R ☐L)
- ㉛ ☐ Palm (☐R ☐L)
- ㉜ ☐ Hip (☐R ☐L)
- ㉝ ☐ Thigh / Femur (☐R ☐L)
- ㉞ ☐ Knee (☐R ☐L)
- ㉟ ☐ Calf/Tibia & Fibula (☐R ☐L)
- ㊱ ☐ Ankle & Hindfoot (☐R ☐L)
- ㊲ ☐ Forefoot & Midfoot (☐R ☐L)
- ㊳ ☐ Arthrogram of _____ (☐R ☐L)

High Resolution Small Parts
- ㊴ ☐ _____ Finger (☐R ☐L)
- ㊵ ☐ _____ Toe (☐R ☐L)
- ㊶ ☐ T-M Joints

Contrast Enhanced MR Angiogram (CE-MRA)
- ㊷ ☐ Renal / Abdominal CE-MRA
- ㊸ ☐ Peripheral CE-MRA
- ㊹ ☐ Pulmonary CE-MRA
- ㊺ ☐ Thoracic Aorta CE-MRA
- ㊻ ☐ Whole Body CE-MRA

Cardiac
- ㊼ ☐ Basic Anatomy & Function
- ㊽ ☐ Viability
- ㊾ ☐ Stress (Adenosine) Perfusion & Viability
- ㊿ ☐ Full Ischaemic Heart Assessment(㊽+㊾+㊿)
- (51) ☐ + CT Coronary Angiogram
- (52) ☐ Cardiomyopathies
- (53) ☐ Volume / Flow Assessment / Flow Quantification

Others
- (54) ☐ Hypertension Assessment (Renal MRA, Kidneys & Adrenals)
- (55) ☐ Whole Body Screening
- (56) ☐ Metal Artifact Reduction
- (57) ☐ _____

Ⓑ Contrast Enhancement: (58) ☐ NON-CONTRAST (59) ☐ NON-CONTRAST & CONTRAST (60) ☐ TO BE DECIDED BY RADIOLOGIST

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

☐*No* ☐*Yes Allergy to Gadolinium (MR Contrast)*
☐*No* ☐*Yes SEVERE Reaction to Allergens*
☐*No* ☐*Yes SEVERE Asthma*
} *if yes, please prescribe steroid premedication* (adult regime: Oral prednisolone 40mg 12 hr. & 2 hr. before contrast MR)

☐*No* ☐*Yes Renal Impairment*
☐*No* ☐*Yes over 60 years old*
☐*No* ☐*Yes Diabetes Mellitus*_____
} *if yes, for contrast MR please provide latest Creatinine* _____ *Date:* _____ *within 2 weeks*

eGFR_____ IV Contrast _____ % Dr. _____

☐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 **Heart disease** _____ Body Weight _____ Kg

☐No ☐Yes **Previous operation** _____ Body Height _____ cm

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

PROVISIONAL CLINICAL DIAGNOSIS IF ANY:

Official use:

take Hx: _____

'er 1: _____ ☐ consen checke

'er 2: _____

Own films _____

Image print _____

Printed old films ____

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

Tel.: _____ Address: _____ Date: _____

Please stick label if available

Patient's Name: _____

Sex/Age: _____ D.O.B.: _____ HKID: _____

Hosp./Hosp.No.: _____ Ward/Rm. No.: _____

MRI SCAN
磁共振掃描
Requisition form