ST. TERESA'S HOSPITAL

SCANNING DEPARTMENT

(CT, MR, NM, PET-CT Scan & Bone Densitometry)

PET-CT SCAN 正電子電腦掃描 Requisition form

PET-CT CODE NO.: PO | Exam. Date:

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

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☐ **Whole Body Trunk** (skull base to upper thigh) (optional contrast)

☐ **Whole Body Trunk** (skull base to upper thigh) **+ Contrast CT of** (with CT report) :

- ☐ **Brain** (with PET Brain)
- ☐ **Neck**
- ☐ **Thorax**
- ☐ **Upper Abdomen** (from diaphragm to iliac crest)
- ☐ **Pelvis** (from iliac crest to symphysis pubis)
- ☐ **Others:** _____

☐ **Whole Body Trunk** (skull base to upper thigh) (non-contrast CT)

☐ **FDG Brain**

☐ **Cardiac - Viability**

Ⓑ **MUST BE COMPLETED:** (if Contrast CT is required)

☐*No* ☐*Yes* *Renal Impairment* *(if yes)*
☐*No* ☐*Yes* *over 60 years old* *(if yes)*
☐*No* ☐*Yes* *Diabetes Mellitus*_____ *(if yes)*
→ *(please provide) latest Creatinine Level*_____ *Date:*_____
Creatinine level result within 2 weeks is preferable
→ *on Metformin* ☐*No* ☐*Yes*
(for contrast CT, advise to withhold Metformin for 48 hours from the date of examination)

☐*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* *Heart disease* _____ ☐*No* ☐*Yes* *Hypertension* _____

☐*No* ☐*Yes* *Previous operation* _____

Patient is pregnant ☐ No ☐ Yes **LMP** _____ **Menopause** ☐ Yes **remarks:** _____

Ⓒ **Preparation:**

* Fasting overnight before examination 檢查前一晚開始禁食
* Please remind patient to bring films from previous examinations 請通知病人帶同舊片
* No dextrose drip 6 hours before scan
* If contrast CT is required, pre-medication (eg. Steroid) should be given to patient with any allergic history

Please stick label if available or use block letter Body Weight _____Kg

Patient's Name: _____

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

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

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

PROVISIONAL CLINICAL DIAGNOSIS IF ANY:

Official use

take Hx: _____

'er 1: _____

'er 2: _____

Own films _____

_____

_____

CD _____

Films _____

Colour print _____

Printed old films _____

Ⓔ **REFERRING DOCTOR:** _____ **Signed:** _____

Tel.: _____ Address: _____ Date: _____