ST. TERESA'S HOSPITAL

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

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PET-MR SCAN
正電子-磁共振掃描

Requisition form

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

Appointment Date: Time:

☐ F-18 FDG Whole Body Trunk PET-MR (non-contrast)
(vertex to upper thigh) with complementary low dose screening CT thorax

☐ F-18 FDG Whole Body Trunk PET-MR and whole body MRI surveillance (non-contrast)
(vertex to upper thigh) with complementary low dose screening CT thorax

☐ Ga-68 PSMA Whole Body Trunk PET-MR (non-contrast)
(vertex to upper thigh) with complementary low dose screening CT thorax

☐ F-18 FDG PET-MR brain
- ☐ non-contrast
- ☐ non-contrast & contrast
- ☐ optional contrast

- ☐ add-on Perfusion
- ☐ add-on Spectroscopy
- ☐ add-on Brain MRA

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- ☐ MRI of Brain
- ☐ MRI of NP/Neck
- ☐ MRI of Breast
- ☐ MRI of Liver/Upper Abdomen
- ☐ MRI of Prostate
- ☐ MRI of Pelvis
- ☐ MRI of Abdomen and Pelvis

\+
- ☐ non-contrast
- ☐ non-contrast & contrast
- ☐ optional contrast

Ⓑ MUST BE COMPLETED: (PLEASE ✓ APPROPRIATE ITEMS)

☐No ☐Yes *Allergy to Gadolinium (MR Contrast) 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, please provide) *latest Creatinine Level*_____ *Date:*_____
Creatinine level result within 2 weeks is preferable

Patient is pregnant ☐No ☐Yes LMP_____ Menopause ☐Yes remarks:_____

Ⓒ PAST MEDICAL HISTORY: (PLEASE ✓ APPROPRIATE ITEMS)

Please stick label if available Body Height____cm Body Weight____Kg

☐No ☐Yes Previous operation_____

Patient's Name: _____

☐No ☐Yes Hypertension_____ ☐No ☐Yes Heart disease
☐No ☐Yes Cardiac pacemaker ☐No ☐Yes Middle ear prosthesis
☐No ☐Yes Ocular metallic foreign body ☐No ☐Yes Neuro-stimulators
☐No ☐Yes Aneurysm clips ☐No ☐Yes Life support system
☐No ☐Yes Metallic implant ☐No ☐Yes Body weight over 300 lbs.

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

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

Please Remind Patients To Bring Films From Previous Examinations 請通知病人帶舊片

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

PROVISIONAL CLINICAL DIAGNOSIS IF ANY:

Official use:
take Hx.:_____
ver 1:_____
ver 2:_____
Own films_____
DVD_____
Films_____
Image print_____
Printed old films_____

Ⓔ REFERRING DOCTOR:_____ Signed:_____

Tel.:_____ Address:_____ Date:_____