ST. TERESA'S HOSPITAL

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

B1 Floor, Main Block, 327 Prince Edward Road, Kowloon.
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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

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- ☐ non-contrast
- ☐ non-contrast & contrast
- ☐ optional contrast

Ⓑ MUST BE COMPLETED: (PLEASE ✓ APPROPRIATE ITEMS)

☐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

☐No ☐Yes *Asthma* _____
☐No ☐Yes *Allergies* (please specified: _____)

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

Ⓒ PAST MEDICAL HISTORY: (PLEASE ✓ APPROPRIATE ITEMS)

☐No ☐Yes **Previous operation** _____

☐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.**

Please stick label if available Body Height ____cm Body Weight ____Kg

Patient's Name: _____

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.: _____
Ser 1: _____
Ser 2: _____
Own films _____
_____
_____
DVD _____
Films _____
Image print _____
Printed old films _____

Ⓔ REFERRING DOCTOR: _____ Signed: _____

Tel.: _____ Address: _____ Date: _____