St. Teresa's Hospital 聖德肋撒醫院

Scanning Department 掃描部

(CT, MR, NM, PET-CT, PET-MR)
B1 Floor, Main Block, 327 Prince Edward Road, Kowloon.
Tel.: (852) 2715 8660 Fax: (852) 2762 2718
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電話: (852) 2715 8660 傳真: (852) 2762 2718
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Online Booking
網上預約

Appointment Date:
Time:

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

☐ F-18 FDG
☐ PSMA
☐ Ga-68 Dotatate
☐ F-18 FDG + C-11 Acetate

☐ **Whole Body Trunk** (skull base to upper thigh) (non-contast CT)
☐ **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:** _____

Others
☐ F-18 FDG Brain
☐ F-18 Cardiac - Viability

Amyloid Brain Scan (Neuraceq®)
☐ Florbetaben (FBB) PET-CT brain
\+ ☐ add-on FDG PET-CT brain

Ⓑ **MEDICAL & PHYSICAL INFORMATION:** (PLEASE ✓ APPROPRIATE ITEMS)

eGFR_____ IV Contrast _____% Dr._____

☐***No*** ☐***Yes Allergy to Iodinated Contrast***
if yes, please prescribe steroid premedication
(adult regime: Oral prednisolone 40mg 12 hr. & 2hr. before contrast CT)

☐***No*** ☐***Yes Renal Impairment***
☐***No*** ☐***Yes Diabetes Mellitus***_____

if yes, for contrast CT please provide ***Latest Creatinine*** _____ ***Date:*** _____ *within 2 weeks*

☐No ☐Yes **Patient is pregnant LMP** _____ ☐ **Menopause** _____ ☐No ☐Yes on **Metformin**

☐No ☐Yes Hypertension _____ ☐No ☐Yes Heart disease _____ Body Weight _____ kg.

☐No ☐Yes Previous operation _____

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

PROVISIONAL CLINICAL DIAGNOSIS:

Official use:

take Hx: _____

'er 1: _____ ☐ consent checked

'er 2: _____

Own films _____

Image print _____

Printed old films _____

Ⓓ **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.:_____

☐ Discharged Patient's Tel. _____

PET-CT SCAN

正電子電腦掃描

Requisition form

MR-SCAN-092 Revised Feb 2025