Gleneagles HONG KONG 港怡醫院

Radiological Examination Request Form

Patient Name: _____

HKID: _____

DOB: _____ Gender: _____

Radiology Department

Appointment Date: _____ **Time:** _____ ❑**Urgent** ❑**Contact Precaution**

Referring Doctor's Details

Doctor Name:_____ Tel: _____ Fax: _____

Address: _____

_____

Clinical Information/ History

L.M.P _____ / Menopause* Allergy History:_____ Asthma: ❑Yes ❑ No

Previous Operation: (Site) _____ (Date) _____(MM/YY)

Please ✓ against ❑ for radiological examination(s) required

❑ **Plain X-ray** (Please specify)

❑ **Fluoroscopy** (Please specify)

❑ **Bone Densitometry** (Spine & Hip)

❑ **Mammography**

❑Bilateral

Unilateral: ❑Right ❑Left

Con Magnification: ❑Right ❑Left ❑Bilateral

❑ **Ultrasound** (Please specify)

❑ **Nuclear Medicine** (Please specify)

❑ **Others** (Please specify)

❑ **Computed Tomography**

Regions: ❑ Plain ❑ Plain and Contrast ❑ Optional Contrast

Creatinine level: _____ µmol/L (within 60 days)

❑ **Magnetic Resonance Imaging**

Regions: ❑ Plain ❑ Plain and Contrast ❑ Optional Contrast

Cardiac pacemaker ❑ Yes ❑ No

Metallic implants ❑ Yes ❑ No

Creatinine level: _____ µmol/L (within 14 days)

PET-CT *(* Skull Base to Upper Thighs, excluding Brain and Extremities.)*

❑ PET-CT F18 FDG Whole Body Trunk* ❑Plain ❑Contrast

❑ PET-CT F18 FDG Brain & Body Trunk* ❑Plain ❑Contrast

❑ PET-CT Dual Tracer Whole Body Trunk* ❑Plain ❑Contrast

❑ PET-CT C-11 Acetate Whole Body Trunk* (Complementary to FDG-PET) ❑Plain ❑Contrast

PET-MR

❑ PET-MR F18 FDG Whole Body Trunk (Plain)

❑with one region plain MRI

(please specify: _____)

❑with one region contrast MRI

(please specify: _____)

Remarks:	Referral Doctor Signature and Chop:

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