

Radiological Examination Request Form

Patient Name: _____
HKID: _____
DOB: _____ Gender: _____

Radiology Department

Appointment Date: _____ Time: _____ Urgent Contact Precaution

Referring Doctor's Details

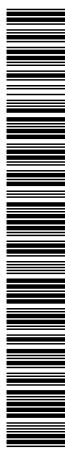
Doctor Name: _____	Tel: _____	Fax: _____
Address: _____		

Clinical Information/ History

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L.M.P _____ / Menopause* Allergy History: _____ Asthma: Yes No
Previous Operation: (Site) _____ (Date) _____ (MM/YY)

Please <input checked="" type="checkbox"/> against <input type="checkbox"/> for radiological examination(s) required	
<input type="checkbox"/> Plain X-ray (Please specify)	<input type="checkbox"/> Computed Tomography Regions: <input type="checkbox"/> Plain <input type="checkbox"/> Plain and Contrast <input type="checkbox"/> Optional Contrast Creatinine level: _____ $\mu\text{mol/L}$ (within 60 days)
<input type="checkbox"/> Fluoroscopy (Please specify)	<input type="checkbox"/> Magnetic Resonance Imaging Regions: <input type="checkbox"/> Plain <input type="checkbox"/> Plain and Contrast <input type="checkbox"/> Optional Contrast Cardiac pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Metallic implants <input type="checkbox"/> Yes <input type="checkbox"/> No Creatinine level: _____ $\mu\text{mol/L}$ (within 14 days)
<input type="checkbox"/> Bone Densitometry (Spine & Hip)	
<input type="checkbox"/> Mammography <input type="checkbox"/> Bilateral Unilateral: <input type="checkbox"/> Right <input type="checkbox"/> Left Con Magnification: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	PET-CT (* Skull Base to Upper Thighs, excluding Brain and Extremities.) <input type="checkbox"/> PET-CT F18 FDG Whole Body Trunk* <input type="checkbox"/> Plain <input type="checkbox"/> Contrast <input type="checkbox"/> PET-CT F18 FDG Brain & Body Trunk* <input type="checkbox"/> Plain <input type="checkbox"/> Contrast <input type="checkbox"/> PET-CT Dual Tracer Whole Body Trunk* <input type="checkbox"/> Plain <input type="checkbox"/> Contrast <input type="checkbox"/> PET-CT C-11 Acetate Whole Body Trunk* (Complementary to FDG-PET) <input type="checkbox"/> Plain <input type="checkbox"/> Contrast
<input type="checkbox"/> Ultrasound (Please specify)	
<input type="checkbox"/> Nuclear Medicine (Please specify)	
<input type="checkbox"/> Others (Please specify)	PET-MR <input type="checkbox"/> PET-MR F18 FDG Whole Body Trunk (Plain) <input type="checkbox"/> with one region plain MRI (please specify: _____) <input type="checkbox"/> with one region contrast MRI (please specify: _____)
Remarks:	Referral Doctor Signature and Chop:



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