聖保祿醫院
St. Paul's Hospital

ZDIM_SOR01_P	(V3) Sep 2019

放射部 RADIOLOGY DEPARTMENT
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Radiology Request Form
Magnetic Resonance Imaging (MRI)

Visit No.: _____ Dept.: _____

Name: _____ Sex/Age: _____

Doc. No.: _____ Adm. Date: _____

Attn. Dr.: _____

Please fill in / affix patient's label

Patient No.: PN_____

Appointment Information

Appointment Date: _____

Appointment Time: _____

Clinical Information:

Patient Pregnant *(Female)*? ☐ Yes ☐ No

Last Menstrual Period (LMP): _____

Previous History of Allergy: _____

Previous Operation: _____

Artificial Heart Valve	☐	Diabetes Mellitus	☐
Claustrophobia	☐	Heart Disease	☐
Cardiac Pacemaker / Defibrillator	☐	Arrhythmia	☐
Hypertension	☐	Cochlear implant	☐
Aneurysm Clips	☐	***None of the above***	☐

MRI

IV Contrast: ☐ Yes ☐ No ☐ Optional

☐	Brain	☐	Brain & MRA
☐	Sella / Pituitary	☐	IAMs
☐	Nasopharynx / Neck	☐	Whole Abdomen
☐	Breasts	☐	Upper Abdomen
☐	MRCP	☐	Perineum (FIA)
☐	Lower Abdomen / Pelvis	☐	Prostate
☐	Wrist (*L / R / Both*)	☐	Shoulder (*L / R / Both*)
☐	Elbow (*L / R / Both*)	☐	Hand (*L / R / Both*) / Finger (specify): _____
☐	Hip (*L / R / Both*)	☐	Knee (*L / R / Both*)
☐	Ankle (*L / R / Both*)	☐	Foot (*L / R / Both*)
☐	Cervical Spine	☐	Thoracic Spine
☐	Lumbar Spine *(Include S1)*	☐	Sacroiliac Joints
☐	Sacral Spine	☐	Coccyx Spine
☐	Whole Spine	☐	Cardiac
☐	Hypertension Package	☐	Stroke Package
☐	Others: _____	☐	Angiogram (specify): _____

Doctor's Name & Signature: _____

Date of Request: _____