聖保祿醫院
St. Paul's Hospital

| ZDIC_SOR01_P | (V3) Sep 2019 |
|---|---|

**放射部 RADIOLOGY DEPARTMENT**
香港銅鑼灣東院道二號地庫一樓 LG1, No.2 Eastern Hospital Road, Causeway Bay, Hong Kong
電話 Tel: 2830-3786 / 2830-3796 傳真 Fax: 2837-5220

# Radiology Request Form
# Computed Tomography (CT)

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): _____

Diabetes Mellitus ☐ Yes ☐ No Previous History of Allergy: _____

## CT

**IV Contrast: ☐ Yes ☐ No ☐ Optional**

- ☐ Brain
- ☐ Paranasal Sinus
- ☐ Nasopharynx
- ☐ Low Dose Lung
- ☐ Upper Abdomen
- ☐ Whole Abdomen
- ☐ Thorax & Whole Abdomen
- ☐ Hand (*L / R / Both*)
- ☐ Ankle (*L / R / Both*)
- ☐ Coronary Arteries & Calcium Score
- ☐ Circle of Willis (COW)
- ☐ Triple Rule Out
- ☐ Lower Limb Arteries
- ☐ Spine (Please specify): _____
- ☐ Facial Bone
- ☐ Neck
- ☐ IAMs/Petrous Bone
- ☐ Thorax
- ☐ Lower Abdomen/Pelvis
- ☐ Urogram
- ☐ Colonoscopy
- ☐ Elbow (*L / R / Both*)
- ☐ Foot (*L / R / Both*)
- ☐ Coronary Arteries only
- ☐ Intra & Extracranial Arteries
- ☐ Thoracic / Abdominal Aorta
- ☐ Lower Limbs (*L / R / Both*)
- ☐ Others : _____

**Doctor's Name & Signature:** _____

**Date of Request:** _____