聖保祿醫院 St. Paul's Hospital

ZDIG_SOR01_P	(V3) Oct 2017	

放射部 RADIOLOGY DEPARTMENT
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Radiology Request Form
Plain X-ray / DEXA / Fluoroscopy / Ultrasound

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): ____________

Plain X-Ray / DEXA / Fluoroscopy

☐ Chest (CXR)	☐ Ribs	☐ Shoulder / Clavicle	☐ Skull
☐ Cervical Spine	☐ Thoracic Spine	☐ Lumbo-sacral Spine	☐ Sacro-coccyx Spine
☐ KUB	☐ Abdomen	☐ Pelvis / Hip	☐ Paranasal Sinuses
☐ Extremity: ____________	*(L / R / Both)*	☐ **OPG**	☐ **DEXA**
☐ Barium Swallow	☐ Barium Meal	☐ Barium Follow Through	☐ Barium Enema
☐ HSG	☐ Voiding Cystogram	☐ **IVU**	☐ ***Others:*** ______

Ultrasound

☐ Neck	☐ Thyroid	☐ Breasts
☐ Liver	☐ Liver & Gall Bladder	☐ Upper Abdomen
☐ Kidneys	☐ Renal System	☐ Testes & Scrotums
☐ Pelvis	☐ Groin	☐ Whole Abdomen
☐ Prostate *(Transrectal / Transabdominal)*	☐ Superficial Mass / Musculoskeletal ____________	
☐ Colour Doppler *(Arteries)* ____________	☐ Colour Doppler *(Lower Limb Veins)* ____________	☐ Varicose Vein Mapping ____________
		☐ ***Others:*** ____________

Doctor's Name & Signature: ____________

Date of Request: ____________