



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.: _____

Patient No.: PN _____

*Please fill in /
affix patient's label*

Appointment Information

Appointment Date: _____

Appointment Time: _____

Clinical Information:

Patient Pregnant (*Female*)? Yes No Last Menstrual Period (LMP): _____

Plain X-Ray / DEXA / Fluoroscopy

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Chest (CXR) | <input type="checkbox"/> Ribs | <input type="checkbox"/> Shoulder / Clavicle | <input type="checkbox"/> Skull |
| <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Lumbo-sacral Spine | <input type="checkbox"/> Sacro-coccyx Spine |
| <input type="checkbox"/> KUB | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Pelvis / Hip | <input type="checkbox"/> Paranasal Sinuses |
| <input type="checkbox"/> Extremity: _____ (<i>L / R / Both</i>) | <input type="checkbox"/> OPG | <input type="checkbox"/> DEXA | |
| <input type="checkbox"/> Barium Swallow | <input type="checkbox"/> Barium Meal | <input type="checkbox"/> Barium Follow Through | <input type="checkbox"/> Barium Enema |
| <input type="checkbox"/> HSG | <input type="checkbox"/> Voiding Cystogram | <input type="checkbox"/> IVU | <input type="checkbox"/> Others: _____ |

Ultrasound

- | | | |
|---|--|--|
| <input type="checkbox"/> Neck (<i>exclude Thyroid</i>) | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Breasts |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Liver & Gall Bladder | <input type="checkbox"/> Upper Abdomen |
| <input type="checkbox"/> Kidneys | <input type="checkbox"/> Renal System | <input type="checkbox"/> Testes & Scrotums |
| <input type="checkbox"/> Pelvis | <input type="checkbox"/> Groin | <input type="checkbox"/> Whole Abdomen |
| <input type="checkbox"/> Prostate (<i>Transrectal / Transabdominal</i>) | <input type="checkbox"/> Superficial Mass / Musculoskeletal _____ | |
| <input type="checkbox"/> Colour Doppler
(<i>Arteries</i>) _____ | <input type="checkbox"/> Colour Doppler
(<i>Lower Limb Veins</i>) _____ | <input type="checkbox"/> Varicose Vein Mapping |
| | | <input type="checkbox"/> Others: _____ |

Doctor's Name & Signature: _____

Date of Request: _____