聖保祿醫院
St. Paul's Hospital

ZDIO_SOR01_P | (V4) July 2025

放射部 RADIOLOGY DEPARTMENT
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Radiology Request Form
Breast Imaging and Intervention

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: _____

Examination / Intervention (Please indicate: ☐ Left / ☐ Right / ☐ Bilateral Breasts)

☐ 2D Mammogram
☐ Ultrasound Breasts Package *(Please also select 2D/3D/Contrast Mammo.)*
☐ 3D Tomosynthesis
☐ Contrast-Enhanced Mammogram
☐ Ductogram _____
☐ Mammogram-guided / ☐ Ultrasound-guided Hookwire Localization_____
☐ Stereotactic Vacuum-Assisted Biopsy (SVAB)_____
☐ Ultrasound-guided Mammotome_____
☐ Others _____

Clinical Information (Please complete all the items and "✓" the appropriate boxes)

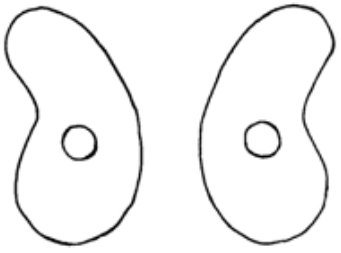
For Female Patient (Age 10-60) ☐ LMP _____ / ☐ Menopause | Is the patient pregnant? ☐ No ☐ Yes

Current breast symptoms: ☐ Lump ☐ Bleeding / Discharge ☐ Pain ☐ Change in breast / nipple shape	☐ No	☐ Yes _____
History of breast cancer	☐ No	☐ Yes _____
History of breast surgery	☐ No	☐ Yes _____
History of other surgery	☐ No	☐ Yes _____
History of chemotherapy / radiation therapy	☐ No	☐ Yes _____
Use of drugs (Estrogen / Contraceptive pills)	☐ No	☐ Yes _____
History of trauma	☐ No	☐ Yes _____
Family history of breast cancer	☐ No	☐ Yes _____
For Contrast-Enhanced Mammogram History of: *(Any of the following)* ☐ Renal Disease ☐ Diabetes on Metformin	☐ No	☐ Yes, please provide serum creatinine within 3-months. *Date:*_____ *Creatinine level:*_____*mmol/L*
History of IV Contrast Allergy?	☐ No	☐ Yes, please specify and arrange pre-medication _____

Remarks:

Skin Mass / Scar / Mole

RIGHT



LEFT

Doctor's Name & Signature: _____

Date of Request: _____

**Please attach this request form for patient admission*