聖保祿醫院
St. Paul's Hospital

| ZDIC_SOR01_P | (V3) Sep 2023 | |
|---|---|---|


放射部 RADIOLOGY DEPARTMENT
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# Radiology Request Form
# Positron Emission Tomography - Computed Tomography (PET-CT)

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: _____

**Please complete all the items and "✓" the appropriate boxes.**

| **Examination Order** | **□Plain** | **□Contrast** | **Body Weight** _____kg |
|---|---|---|---|
| ☐ F18-FDG Whole Body Trunk (from Skull Base to Groin) | | | |
| ☐ F18-FDG Whole Body Trunk with Brain (from Brain to Groin) | | | |
| ☐ Ga68-PSMA Whole Body Trunk (From Skull Base to Groin) | | | |

| **Additional Region** *(Please specify the indication e.g. melanoma)* | | **Additional Regional Contrast CT** *(Please specify the region & indication e.g. HCC)* | |
|---|---|---|---|
| ☐ Upper Limbs | | ☐ Abdomen | |
| ☐ Lower Limbs | | ☐ Others | |

**Clinical Information**

_____

| | | |
|---|---|---|
| History of adverse drug reaction | ☐ Yes, please specify _____ | ☐ No |
| History of adverse reaction to contrast media | ☐ **Yes** **(For contrast exam, please arrange pre-medication)** | ☐ No |
| For female patient (Age 10-60) | ☐ LMP _____ (For LMP over 10 days from the exam, please arrange pregnancy test in advance or patient is required to sign pregnancy test refusal form) | ☐ Menopause<br>☐ Pregnant<br>☐ Lactating |
| History of Claustrophobia | ☐ Yes | ☐ No |
| History of Diabetes | ☐ Yes | ☐ No |
| Diabetes on Metformin | ☐ Yes Please specify _____ | ☐ No |
| History of Renal Impairment | ☐ Yes | ☐ No |
| Hypertension on Medication | ☐ Yes | ☐ No |
| For patient with Diabetes Mellitus or Hypertension, or Renal Impairment | Please provide the latest serum creatinine level within 30 days.<br>Creatinine Level _____ mmol/L Date _____ | |

**Studies Comparison**
Please send ALL the old films, CDs and reports of correlative studies for reference.

**Cancellation Policy**
Radiopharmaceuticals will be charged if it is cancelled within a) 1-working day for FDG-18 PET-CT scan, or b) 2-working days for PSMA PET-CT scan prior to the exam respectively. (HK$ 2,500 for FDG-18 / HK$ 5,000 for PSMA)

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

**Date of Request:** _____