聖保祿醫院
St. Paul's Hospital

ZDIC_SOR01_P | (V4) Jan 2025

放射部 RADIOLOGY DEPARTMENT
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Radiology Request Form
Magnetic Resonance Imaging (MRI)

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: _____

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

Clinical Information:

_____

Previous Surgery:	☐ No ☐ Yes _____	Claustrophobia	☐ No ☐ Yes
IV Contrast Allergy:	☐ No ☐ Yes _____	Artificial Heart Valve	☐ No ☐ Yes
Renal Disease:	☐ No ☐ Yes _____	Aneurysm Clips	☐ No ☐ Yes
Diabetes Mellitus:	☐ No ☐ Yes _____	Cochlear Implant	☐ No ☐ Yes
For Female Patient (Age 10-60)		Cardiac Defibrillator	☐ No ☐ Yes
LMP: _____	/ ☐ Menopause	Pacemaker / Loop Recorder	☐ No ☐ Yes
Is the patient pregnant?	☐ No ☐ Yes	Deep Brain Stimulator	☐ No ☐ Yes
		Surgical Clips /Coils /Stent	☐ No ☐ Yes

IV Contrast: ☐ Yes ☐ No ☐ Optional (To be decided by radiologist)

- ☐ Brain
- ☐ Brain & MRA-Circle of Willis
- ☐ Internal Auditory Meatus (IAMs)
- ☐ Sella / Pituitary Gland
- ☐ Orbits
- ☐ Nasopharynx / Soft Tissue Neck
- ☐ MRCP *(Plain cholangiogram only)*
- ☐ Abdomen *(Upper Abdomen)* _____
- ☐ Pelvis *(Lower Abdomen)*
- ☐ Whole Abdomen *(Abdomen & Pelvis)*
- ☐ Prostate
- ☐ Perineum (FIA)
- ☐ Whole Spine
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine *(Include S1)*
- ☐ Sacral Spine / ☐ Coccygeal Spine
- ☐ Superficial mass _____
- ☐ Stroke Package
- ☐ Hypertension Package
- ☐ Breasts
- ☐ Cardiac: _____
- ☐ Angiogram (Specify: _____)
- ☐ Shoulder (☐ L / ☐ R)
- ☐ Elbow (☐ L / ☐ R)
- ☐ Wrist (☐ L / ☐ R)
- ☐ Hand (☐ L / ☐ R)
- ☐ Finger (☐ L / ☐ R) (Specify: _____)
- ☐ Hip (☐ L / ☐ R)
- ☐ Knee (☐ L / ☐ R)
- ☐ Ankle & Hindfoot (☐ L / ☐ R)
- ☐ Forefoot (☐L / ☐ R) / Toe (Specify: _____)
- ☐ Extremity (☐ L / ☐ R) (Specify: _____)
- ☐ Whole Body Screening / ☐ Skeletal Survey
- ☐ RT Planning (☐ Brain / ☐ Others: _____)
- ☐ Others: _____

Doctor's Name & Signature: _____ Date of Request: _____

**Please attach this request form for patient admission.*