聖保祿醫院
St. Paul's Hospital

| ZDIC_SOR01_P | (V4) Feb 2025 |
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**放射部 RADIOLOGY DEPARTMENT**
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# Radiology Request Form
# Computed Tomography (CT)

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:**

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

***For Contrast CT***

History of: *(Any of the following)* ☐ No ☐ Yes, please provide the serum creatinine level within 3 months
☐ Renal Disease Creatinine Level: _____mmol/L
☐ Diabetes on Metformin Date: _____

History of Contrast Allergy: ☐ No ☐ Yes, please specify and arrange pre-medication: _____

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

- ☐ Brain
- ☐ Paranasal Sinuses
- ☐ Facial Bone / Orbits
- ☐ IAMs / Petrous Bone / Sella
- ☐ Neck (Soft Tissue Neck) / Nasopharynx
- ☐ Low Dose Lung *(Non-contrast only)*
- ☐ Thorax
- ☐ Thorax & HRCT
- ☐ Abdomen *(Upper Abdomen)*
- ☐ Pelvis *(Lower Abdomen)*
- ☐ Whole Abdomen *(Abdomen & Pelvis)*
- ☐ Urogram
- ☐ Whole Abdomen with Urogram
- ☐ Thorax & Whole Abdomen
- ☐ CT Colonoscopy
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Sacral & Coccygeal Spine
- ☐ Extremities (Please specify: _____)
- ☐ Circle of Willis
- ☐ Circle of Willis *(include Brain)*
- ☐ Carotid & Vertebral Arteries
- ☐ Intra & Extracranial Arteries
- ☐ Intra & Extracranial Arteries (*include Brain*)
- ☐ Pulmonary Arteries
- ☐ Pulmonary Arteries (*include Thorax*)
- ☐ Coronary Arteries & Calcium Score
- ☐ Coronary Arteries only
- ☐ Triple Rule Out
- ☐ Thoracic Aorta
- ☐ Thoracic Aorta (*include Thorax*)
- ☐ Abdominal Aorta
- ☐ Abdominal Aorta (*include Whole Abdomen*)
- ☐ Hypertension Package
- ☐ Coeliac, Hepatic & Mesenteric Arteries
- ☐ CTA Upper Limbs
- ☐ CTA Lower Limbs
- ☐ Others: _____

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

**Please attach this request form for patient admission*