



放射部 RADIOLOGY DEPARTMENT

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# Radiology Request Form

## Fluoroscopy / Interventional Radiology

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:

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

### Fluoroscopy

- |  |  |
|--|--|
| <input type="checkbox"/> Barium / <input type="checkbox"/> Water-Soluble Contrast Swallow        | <input type="checkbox"/> Insertion of Nasogastric Tube (Ryle's Tube)               |
| <input type="checkbox"/> Barium / <input type="checkbox"/> Water-Soluble Contrast Meal           | <input type="checkbox"/> VFSS  |
| <input type="checkbox"/> Barium / <input type="checkbox"/> Water-Soluble Contrast Follow Through | <input type="checkbox"/> HSG   |
| <input type="checkbox"/> Barium / <input type="checkbox"/> Water-Soluble Contrast Enema          | <input type="checkbox"/> Sialogram   |
| <input type="checkbox"/> T-Tube Cholangiogram  | <input type="checkbox"/> Antegrade / <input type="checkbox"/> Retrograde Pyelogram |
| <input type="checkbox"/> Ascending Urethrogram   | <input type="checkbox"/> Sinogram  |
| <input type="checkbox"/> Cystogram   | <input type="checkbox"/> Fistulogram   |
| <input type="checkbox"/> Voiding Cystogram   | <input type="checkbox"/> Others _____  |

### Interventional Radiology (\*Please specify the site of intervention and type of imaging guidance)

- |   |  |
|---|--|
| <input type="checkbox"/> Percutaneous Transhepatic Biliary Drainage (PTBD)    | <input type="checkbox"/> Aspiration: _____           |
| <input type="checkbox"/> Percutaneous Nephrostomy (PCN) _____                 | <input type="checkbox"/> Biopsy: _____               |
| <input type="checkbox"/> Central Venous Catheter (PICC) _____                 | <input type="checkbox"/> Drainage: _____             |
| <input type="checkbox"/> Angiogram / <input type="checkbox"/> Venogram: _____ | <input type="checkbox"/> Injection: _____            |
| <input type="checkbox"/> Angioplasty: _____                                   | <input type="checkbox"/> Revision of Catheter: _____ |
| <input type="checkbox"/> Embolisation: _____                                  | <input type="checkbox"/> Stenting: _____             |
| <input type="checkbox"/> Others: _____  |  |

Doctor's Name & Signature: \_\_\_\_\_ Date of Request: \_\_\_\_\_