聖保祿醫院
St. Paul's Hospital

ZDIG_SOR03_P	(V6) Feb 2025	

放射部 RADIOLOGY DEPARTMENT
香港銅鑼灣東院道二號地庫一樓 LG1, No.2 Eastern Hospital Road, Causeway Bay, Hong Kong
電話 Tel: 2830-3786 / 2830-3796 傳真 Fax: 2837-5220 **WhatsApp** 5795-2900

Radiology Request Form
Plain X-ray / DEXA / Ultrasound

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

Plain X-Ray *(Please specify the site and projections)*

☐ Chest	☐ Clavicle / ☐ Sternum	☐ Pelvis
☐ Ribs	☐ Shoulder (L / R / Both)	☐ Hip (L / R / Both)
☐ KUB / ☐ Abdomen	☐ Humerus (L / R / Both)	☐ Femur (L / R / Both)
☐ Cervical Spine	☐ Elbow (L / R / Both)	☐ Knee (L / R / Both)
☐ Thoracic Spine	☐ Forearm (L / R / Both)	☐ Lower Leg (L / R / Both)
☐ Lumbo-Sacral Spine	☐ Wrist (L / R / Both)	☐ Ankle (L / R / Both)
☐ Sacro-Coccyx Spine	☐ Hand (L / R / Both)	☐ Foot (L / R / Both)
☐ Skull	☐ Finger (L / R) _______________	☐ Toe (L / R) _________________
☐ Paranasal Sinuses	☐ Others ____	

DEXA

☐ Routine (Lumbar Spine & Hip)	☐ Others (Forearm)	☐ Others (Whole Body)

Ultrasound *(Please specify the site of examination)*

☐ Neck *(exclude Thyroid)*	☐ Thyroid	☐ Breasts (L / R / Both)	☐ Upper Abdomen
☐ Liver	☐ Liver & Gall Bladder	☐ Kidneys	☐ Renal Systems
☐ Pelvis	☐ Testes & Scrotums	☐ Groin (L / R/ Both)	☐ Whole Abdomen

☐ Prostate (☐ Trans-rectal / ☐ Trans-abdominal)

☐ Superficial Mass / Musculoskeletal _______________

☐ Colour Doppler (Arteries):_____________________

☐ Varicose Vein Mapping: (L / R / Both) ____________

☐ Upper / ☐ Lower Limb Venous Doppler (L / R / Both)

☐ Others: ______________________________________

☐ Ultrasound-Guided IR Procedure: ____

Doctor's Name & Signature: ______________________________ Date of Request: ____________________

* *Please attach this request form for patient admission*