聖保祿醫院
St. Paul's Hospital

ZDIC_SOR01_P | (V4) Feb 2025

Radiology Request
Computed Tomography (CT)

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

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)*
- ☐ Renal Disease
- ☐ Diabetes on Metformin

☐ No ☐ Yes, please provide the serum creatinine level within 3 months
Creatinine Level: _____mmol/L
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*