聖保祿醫院
St. Paul's Hospital

ZDIF_SOR03_P | (V1) 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
# Fluoroscopy / Interventional Radiology

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: _____

**Clinical Information:**

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

## Fluoroscopy

☐ Barium / ☐ Water-Soluble Contrast Swallow

☐ Barium / ☐ Water-Soluble Contrast Meal

☐ Barium / ☐ Water-Soluble Contrast Follow Through

☐ Barium / ☐ Water-Soluble Contrast Enema

☐ T-Tube Cholangiogram

☐ Ascending Urethrogram

☐ Cystogram

☐ Voiding Cystogram

☐ Insertion of Nasogastric Tube (Ryle's Tube)

☐ VFSS

☐ HSG

☐ Sialogram

☐ Antegrade / ☐ Retrograde Pyelogram

☐ Sinogram

☐ Fistulogram

☐ Others _____

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

☐ Percutaneous Transhepatic Biliary Drainage (PTBD)

☐ Percutaneous Nephrostomy (PCN) _____

☐ Central Venous Catheter (PICC) _____

☐ Angiogram / ☐ Venogram: _____

☐ Angioplasty: _____

☐ Embolisation: _____

☐ Aspiration: _____

☐ Biopsy: _____

☐ Drainage: _____

☐ Injection: _____

☐ Revision of Catheter: _____

☐ Stenting: _____

☐ Others: _____

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

**Please attach this request form for patient admission*