

養和醫院

HONG KONG SANATORIUM & HOSPITAL

診斷及介入放射部 Tel: 2835 8900

Fax: 2892 7530

Department of Diagnostic & Interventional Radiology

姓名 Name		
年歲 Age	性別 Sex	香港身份證號碼 HK ID No.
房 / 床號 Ward / Bed No.	F / M	醫院號數 Hospital No.

Ref. Dr. _____ Ref. No. _____ Date _____ / _____ / _____
dd / mm / yy

(A) GENERAL INFORMATION

- Urgent (Last Food & Drink at _____)
- Routine
- Follow up Scan No. & Date _____
- Date & No. of Correlative Investigation:
 - MRI _____
 - CT/US _____
 - X-Ray _____

SCAN DEPT. USE ONLY

Date of Exam. _____

- CT No. _____
- Examination No. _____
- Serial No. _____ No. of Films _____
- Operator _____ Disc No. _____
- Contrast _____ Injector _____

If patient over 60 years old

Blood test: Creatinine _____ (Normal: M: 71-124, F: 53-97 $\mu\text{mol/l}$, 0.8-1.4, 0.6-1.1 mg/dl)
Urea _____ (Normal: 1.67-8.35 mmol/l, 10-50 mg/dl)

(B) MEDICAL HISTORY (Must be completed)

- History of Reaction of Previous Contrast Injection (Specify) _____
- History of Asthma _____
- History of Other Allergies (Specify) _____
- History of Diabetes Mellitus History of kidney diseases _____
- History of Heart Disease _____
- History of Previous Operation _____
- Others _____
- L M P on: _____

(C) CLINICAL DATA & DIAGNOSIS

(Ci) ANY POSITIVE FINDINGS IN PREVIOUS EXAMINATIONS (X-RAY, US, CT, MR, PET-CT) OF THE SAME REGION ?

請帶回舊片以作比較，多謝合作。

* Please send all old films with patient during examination and reporting for reference or comparison.

(D) REQUEST FOR CT SCAN

NEURO. HEAD & NECK

BODY

CT ANGIOGRAM

- | | | | | |
|---------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------|----------------------------------------------|
| <input type="checkbox"/> Plain Study Only | <input type="checkbox"/> Brain | <input type="checkbox"/> Thorax | <input type="checkbox"/> Low Dose | <input type="checkbox"/> Circle of Willis |
| <input type="checkbox"/> Contrast Study Only | <input type="checkbox"/> Pituitary Fossa | <input type="checkbox"/> Abdomen* | | <input type="checkbox"/> Carotid Bifurcation |
| <input type="checkbox"/> Plain & Contrast Studies | <input type="checkbox"/> Neck | <input type="checkbox"/> Pelvis | | <input type="checkbox"/> Thoracic Aorta |
| <input type="checkbox"/> Contrast Study Optional | <input type="checkbox"/> Paranasal Sinus | <input type="checkbox"/> CT Urogram | | <input type="checkbox"/> Abdominal Aorta |
| (to be given if necessary) | <input type="checkbox"/> Face | <input type="checkbox"/> CT Bronchoscopy | | <input type="checkbox"/> Renal Artery |
| | <input type="checkbox"/> Nasopharynx <input type="checkbox"/> Parotid | <input type="checkbox"/> CT Colonoscopy | | <input type="checkbox"/> SMA |
| DENTAL | <input type="checkbox"/> Larynx <input type="checkbox"/> Maxilla | <input type="checkbox"/> Spine (Level/s of Scan at) _____ | | <input type="checkbox"/> Coeliac Artery |
| <input type="checkbox"/> Upper Jaw (Maxilla) | <input type="checkbox"/> Thyroid <input type="checkbox"/> Mandible | | | <input type="checkbox"/> Pulmonary Artery |
| <input type="checkbox"/> Lower Jaw (Mandible) | <input type="checkbox"/> Orbits | <input type="checkbox"/> Extremity _____ | | <input type="checkbox"/> Others _____ |
| <input type="checkbox"/> Both Upper and Lower Jaw | <input type="checkbox"/> Temporal Bone | <input type="checkbox"/> B M D | | |
| | <input type="checkbox"/> Middle Ear | <input type="checkbox"/> Other Region/s _____ | | |

*Abdomen scans cover top of diaphragm to aortic bifurcation



Signed _____