

# 養和醫院

HONG KONG SANATORIUM & HOSPITAL, LTD.

磁力共振檢查表

MAGNETIC RESONANCE IMAGING REQUEST FORM

Tel : 2835 8902 Fax : 2892 7530

姓名 Name	_____
年歲 Age	_____ 性別 Sex
房 / 床號 Ward / Bed No.	_____ 醫院號數 Hospital No.

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date \_\_\_\_\_  
 Ref. Dr. \_\_\_\_\_ Hosp. No. \_\_\_\_\_ Ward/Dept. \_\_\_\_\_

**(A) GENERAL INFORMATION** **MRI DEPT. USE ONLY**  
 Urgent  Routine M.R.I. No. \_\_\_\_\_ Exam. ID. \_\_\_\_\_

**(B) MEDICAL HISTORY (Must be completed)** Body Weight \_\_\_\_\_

<b>Yes</b>	<b>Yes</b>	<b>Yes</b>
<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Tattoo	<input type="checkbox"/> History of Previous Operation Give Details _____
<input type="checkbox"/> Cardiac-Pacemaker	<input type="checkbox"/> Heart Valve	<input type="checkbox"/> History of Asthma
<input type="checkbox"/> Metallic Implant	<input type="checkbox"/> Intravascular Stent, Model _____	<input type="checkbox"/> History of Previous Contrast Reaction Give Details _____
Location _____	<input type="checkbox"/> History of Hypertension	<input type="checkbox"/> COAD
<input type="checkbox"/> Neuro Stimulators	<input type="checkbox"/> History of Diabetes Mellitus	<input type="checkbox"/> Others _____
<input type="checkbox"/> Ocular Metallic Foreign Body	<input type="checkbox"/> History of Heart Disease	<input type="checkbox"/> LMP _____
<input type="checkbox"/> Aneurysm Clips	<input type="checkbox"/> Heart Block	
<input type="checkbox"/> Middle Ear Prosthesis	<input type="checkbox"/> History of Allergies	

**(C) CLINICAL DATA & DIAGNOSIS**  
**(Ci) ANY POSITIVE FINDINGS IN PREVIOUS EXAMINATIONS (X-RAY, US CT, MR, PET-CT) OF THE SAME REGION?**

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

**(D) REQUEST FOR MRI SCAN**

<input type="checkbox"/> Plain Study Only	<input type="checkbox"/> Neuro & Spine	<input type="checkbox"/> Cardiac Packages
<input type="checkbox"/> Contrast Study Only	<input type="checkbox"/> Stroke Package *	<input type="checkbox"/> Cardiac Anatomy, Function, Myocardial Viability, Stress & Rest Myocardial Perfusion.
<input type="checkbox"/> Plain & Contrast Studies	<input type="checkbox"/> Brain	<input type="checkbox"/> Anatomy & Function (L. ventricle)
<input type="checkbox"/> Contrast Study Optional (to be given if necessary)	<input type="checkbox"/> Brain Stem	<input type="checkbox"/> Function - <input type="checkbox"/> both ventricles <input type="checkbox"/> valves
<input type="checkbox"/> MR Angiography	<input type="checkbox"/> Sella & Pituitary	<input type="checkbox"/> Myocardial viability
<input type="checkbox"/> Circle of Willis	<input type="checkbox"/> EPI (DWI) & ADC map	<input type="checkbox"/> Stress Myocardial Perfusion with Adenosine
<input type="checkbox"/> Carotid Bifurcation	<input type="checkbox"/> Brain perfusion	<input type="checkbox"/> Coronary angiogram (Limited)
<input type="checkbox"/> Hepatic	<input type="checkbox"/> Brain spectroscopy	<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Renal	<input type="checkbox"/> Brain Functional MRI	
<input type="checkbox"/> Aorta - Thoracic	<input type="checkbox"/> Diffusion Tensor Imaging	<input type="checkbox"/> CT Coronary Angiogram + MR Cardiac Package
<input type="checkbox"/> Aorta - Abdominal	<input type="checkbox"/> Skull Base	<input type="checkbox"/> CT Coronary Angiogram + MR Stress & Rest Perfusion
<input type="checkbox"/> Lower extremity	<input type="checkbox"/> IAM R _____ L _____	<input type="checkbox"/> CT Coronary Angiogram + MR Stress & Rest Perfusion + Myocardial Viability
<input type="checkbox"/> Pulmonary Artery	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> CT Coronary Angiogram + MR Stress & Rest Perfusion + Myocardial Viability + Cardiac Anatomy & Function
<input type="checkbox"/> Others (Specify) _____	<input type="checkbox"/> Thoracic Spine	
	<input type="checkbox"/> Lumbar Spine	
	<input type="checkbox"/> Whole Spine Screening	
	<input type="checkbox"/> Sacrum	
<b>Musculo Skeletal System</b>	<b>Head &amp; Neck</b>	<b>Body</b>
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Orbits	<input type="checkbox"/> Non-contrast Whole Body screen
<input type="checkbox"/> Elbow	<input type="checkbox"/> Paranasal Sinuses	<input type="checkbox"/> Non-contrast Thorax & Abdomen screen
<input type="checkbox"/> Wrist	<input type="checkbox"/> Nasopharynx	<input type="checkbox"/> Non-contrast Thorax & Pelvis screen
<input type="checkbox"/> Hip	<input type="checkbox"/> Oropharynx	<input type="checkbox"/> Non-contrast Abdomen & Pelvis screen
<input type="checkbox"/> Knee	<input type="checkbox"/> Hypopharynx	<input type="checkbox"/> Non-contrast Thorax, Abdomen & Pelvis screen
<input type="checkbox"/> Ankle	<input type="checkbox"/> Larynx	<input type="checkbox"/> Whole Body Angiogram with contrast
<input type="checkbox"/> Arthrogram _____	<input type="checkbox"/> Neck	<input type="checkbox"/> MR Metastatic Imaging with contrast Prostate
<input type="checkbox"/> MR Bone Scan Non-contrast	<input type="checkbox"/> TMJ R _____ L _____	<input type="checkbox"/> Supra pubic coil
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Endorectal coil
		<input type="checkbox"/> Spectroscopy

\* MRI Brain (non-contrast), DWI, MRA Brain, & MRA Neck  
 ▲ MRA Renal artery, MRI Kidney, MRI Adrenal



Signature \_\_\_\_\_