Form IC/01[1b]

Please adhere Patient Label
PATIENT DETAILS:

matilda
International Hospital
明 德 國 際 醫 院

41, Mount Kellett Road, The Peak, Hong Kong
Tel: 2849 1540 Fax: 2849 2572

CT Scan Request Form

☐ CD ☐ Film

Date of Exam:_____ **Time :** _____ ☐ **Plain Study** ☐ **With & without Contrast** ☐ **Contrast Optional**

Head & Neck

- ☐ Brain
- ☐ Pituitary Fossa
- ☐ Neck
- ☐ Paranasal Sinus
- ☐ Nasopharynx
- ☐ Temporal Bone & IAM
- ☐ Orbits
- ☐ Thyroid
- ☐ Facial Bone
- ☐ Others _____

CT Angiogram

- ☐ Cerebral
- ☐ Carotid
- ☐ Thoracic Aorta
- ☐ Pulmonary Artery
- ☐ Lower Limbs arteries
- ☐ Coronary
- ☐ Renal Artery
- ☐ Coeliac Artery
- ☐ Abdomen
- ☐ Others _____

Body

- ☐ Calcium Score
- ☐ Thorax ☐ Low dose Lung screening
- ☐ Abdomen (from top of diaphram to aortic bifurcation)
- ☐ Whole Abdomen (Abdomen & Pelvis)
- ☐ Pelvis
- ☐ CT Urogram
- ☐ Whole body (Thorax, Abdomen & Pelvis)
- ☐ Virtual Colonoscopy
- ☐ Spine: Levels at _____
- ☐ Extremity _____
- ☐ Others _____

Dental

- ☐ Upper Jaw (Maxilla)
- ☐ Lower Jaw (Mandible)
- ☐ Others _____

Clinical Data & Diagnosis

(Please bring along old films and/or report for comparison)

Standard Precaution	☐
Contact Precaution	☐
Droplet Precaution	☐

Medical History

(To be completed for patient required IV contrast injection):

Yes No

- ☐ ☐ History of reaction to previous contrast injection (specify) _____
- ☐ ☐ History of asthma
- ☐ ☐ History of other allergies (specify) _____
- ☐ ☐ History of Diabetes Mellitus
- ☐ ☐ History of kidney disease
- ☐ ☐ For patients aged > 60 years, please provide renal function:
  Creatinine: _____ umol / L Urea: _____ umol / L

Patient need to fast 4 hours before the procedure

Department Use:

CT No.:

Operator:

Radiologist / Cardiologist:

LMP: _____

Chance of pregnancy:
☐ YES ☐ NO

Signed & Print Dr's Name:_____

☐ **Bill Doctor** ☐ **Bill Patient**