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

IMAGING DEPARTMENT RADIOLOGICAL REQUEST FORM

X-Ray no.: ______________________ Exam Date: ______________

U/S no.: ______________________ ☐ Film

DEXA no.: ______________________ ☐ DVD

Mammogram no.: ______________________

CT no.: ______________________

EXAMINATION(S) REQUESTED:

Please Specify

Plain X-ray/Special X-ray			
Bone Densitometry	☐ Bone DEXA	☐ Total Body Scan	☐ Ca Score
Mammography	☐	☐ Breasts Ultrasound	
Ultrasound	☐ Upper Abdomen	☐ Echo	☐ Brain
	☐ Whole Abdomen	☐ Renal	☐ Thyroid
Others: ______	☐ Pelvis	☐ With Urinary Bladder	☐ Neck
	☐ Trans-Abdominal	☐ Carotid	☐ Testes
______	☐ Trans-Vaginal	☐ Intima Media Thickness	☐ Doppler of: ______
	☐ Prostate	☐ Obstetric	
______	☐ Trans-Abdominal	☐ Bladder	☐ Groin
	☐ Trans-Rectal	☐ Appendix	☐ Hips
Ultrasound Guided ☐ Fine Needle Aspiration ☐ Core Biopsy	☐ Breast ☐ Right ☐ Left	☐ Thyroid ☐ Neck	☐ Others: ______

Please bring your old films for comparison.

☐ Bill Patient *☐ Bill Doctor*

CLINICAL DATA & DIAGNOSIS:

Standard Precaution	☐
Contact Precaution	☐
Droplet Precaution	☐

Dr.'s Signature: ______________________ Nurse's Signature (for Dr.'s verbal order): ______________

Patient's Transport: ○ Walk ○ Wheelchair ○ Bed/Trolley ○ Non-Transferable(Portable exam request)

Medical History (To be completed for patient who require 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

FOR OFFICIAL USE:

No. of Exposure			
Exp. Factor	Kv/mAs		

Gonad shield applied to patient? ☐ YES ☐ NO

LMP : ______________

Chance of pregnancy: ☐ YES ☐ NO

Radiographer's Initials: ______________