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

Form IC/01[1a]

IMAGING CENTRE RADIOLOGICAL REQUEST FORM

X-Ray no.: ______

U/S no.: ______

DEXA no.: ______

Mammogram no.: ______

CT no.: ______

Exam Date: ______

☐ Film

☐ DVD

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	☐ Appendix	☐ Hips
______	☐ Prostate	☐ Carotid	☐ Testes
	☐ Trans-Abdominal	☐ I M T	☐ Doppler of: ______
	☐ Trans-Rectal	☐ O B S	______

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

Please bring your old films for comparison.

CLINICAL DATA & DIAGNOSIS:

☐ *Bill Patient* ☐ *Bill Doctor*

Standard Precaution	☐
Contact Precaution	☐
Droplet Precaution	☐

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

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

L.M.P : ______

Chance of pregnancy: ☐ YES ☐ NO

Radiographer's Initials: ______

Compiled by Imaging Centre (IC)
Revised by IC
Approved by Joanna Lo
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Effective since 2011