MAGNETIC RESONANCE IMAGING REQUEST FORM 磁力共振掃描申請表

(Please affix barcode label if available)
ID No.
Name
Sex / Age DOB
Hospital
Unit / Ward
Tel.

HKU Med LKS Faculty of Medicine
Department of Diagnostic Radiology
香港大學放射診斷學系

LG3, The Hong Kong Jockey Club Building for Interdisciplinary Research,
5 Sassoon Road, Pokfulam, Hong Kong
香港薄扶林沙宣道五號香港賽馬會跨學科研究大樓地庫三
Tel: (852) 2817 0373 Fax: (852) 2817 4013

MRI Examination ☐ Plain ☐ Contrast

Neuro

- Brain ☐
- Stroke Package (With Cerebral MRA + Carotid MRA) ☐
- Epilepsy Package (+ 3DSPGR) ☐
- Plus Brian Spectroscopy (MRS) ☐
- Plus Functional MRI (fMRI) ☐
- Plus Brain MRA ☐
- Plus Brain MRV ☐
- Plus Brain Perfusion ☐
- Plus CSF Flow ☐
- T1 Fatsat Neck ☐
- Vessel Wall Imaging ☐

Whole Body

- Whole Body Myopathy ☐
- Other (Specify)_____ ☐

Musculoskeletal

- Cervical Spine ☐
- Thoracic Spine ☐
- Lumbar Spine ☐
- Sacrum ☐
- Whole Spine Screening ☐
- Soft Tissue / Muscle ☐
- Scoliosis ☐
- Other (Specify) _____ ☐

Head & Neck

- Salivary Glands ☐
- Orbits ☐
- Face ☐
- Tongue ☐
- Oral Cavity ☐
- Internal Auditory Canal (IAC) ☐
- Skull Base / Nasopharynx (NP) ☐
- Pharynx / Larynx ☐
- Paranasal Sinuses ☐
- Pituitary _____ ☐
- Other (Specify) _____ ☐

Cardiovascular

- Cardiac (Non-Stress Study) ☐
- Cardiac (Stress Study) ☐
- MR Angiography (Thoracic Aorta) ☐
- MR Angiography (Abdominal Aorta) ☐
- MR Angiography (Renal Arteries) ☐
- ☐

Body

- Abdomen (Liver / Pancreas / Spleen) ☐
- Abdomen & MRCP ☐
- Liver (Primovist) ☐
- Liver & MRCP (Primovist) ☐
- Adrenals ☐
- Kidneys ☐
- Prostate ☐
- Pelvis ☐
- Abdomen & Pelvis ☐
- Mediastinum / Thorax ☐
- MR Urogram (MRU) ☐
- Rectum ☐
- Other (Specify) _____ ☐

Clinical Information

Clinical History:

BIOHAZARD ☐ Yes ☐ No ☐ Unknown

Previous Surgery (If yes, please specify Date, Type & Site): ☐ Yes ☐ No

History of kidney disease or dialysis? ☐ Yes ☐ No

Diagnosis:

Does the patient have raised serum creatinine? ☐ Yes ☐ No
(If yes, please provide the following information)
Serum creatinine level: _____ μmol/L
Date of Measurement: _____

Is the patient pregnant? 病人是否懷孕? ☐ Yes ☐ No
LMP 最近一次經期之首天 _____

Referring Doctor's Information

Doctor's Name (Block Letter):		Signature:	Pager / Mobile:	Films & report delivery: ☐ Collect by patient ☐ Send to address (specify):
Hospital:	Department:	Date:	Tel:	

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To be filled in by the referring clinician. Request may be rejected if the following checklist is not properly completed.

The Following items can be hazardous to the patient's safety and may also interfere with MR imaging. Please complete the following checklist by marking the appropriate box with a tick. 病人體內如懷有以下物體可能不適宜進行磁力共振檢查，請小心填報下列表格：

		有 Yes	無 No
Cardiac pacemaker / defibrillator	心臟起搏器 / 除顫器		
Brain clips / Vascular clips	腦動脈 / 血管夾子		
Neurostimulators	神經激動器		
Heart Valve	人工心瓣膜		
Insulin pump	內植胰島素泵		
Implanted perfusion pump	內植灌注泵		
Electrodes	體內電極		
Hearing aids / devices	助聽器		
Cochlear / Occular Implants	耳蝸或眼部移植物		
Shunts	體內分流器		
Joint replacements	人工關節		
History of fractured bone with metal rods, pins, screws, nails or clips	骨折金屬固定物：金屬棒螺絲、釘子、夾子		
Prosthesis	義肢		
Metal mesh	金屬篩網		
Wire sutures	金屬縫線		
Shrapnel / metallic fragments	體內金屬碎片		

		有 Yes	無 No
Permanent eyeliner tattoos	永久性紋眉		
Dentures	假牙		
I.U.C.D	金屬宮內避孕器		
Has the patient been exposed to metal fragment at work?	病人的工作是否與金屬碎片接觸?		
Any intra-orbital metallic F.B.?	眼眶內有否其他金屬物體?		
Other metal in body?	體內有否其他金屬物體?		
Please specify location of metallic F.B. (If any): 請詳細說明金屬異物所在的部位			
Any history of allergy?	有否過敏史?		
Please specify, if any: 如曾有過敏反應，請說明：			
Claustrophobia			
Life Support System			

