香港中文大學醫院
CUHK
Medical Centre

IMAGING AND INTERVENTIONAL RADIOLOGY CENTRE IMAGING REQUEST FORM

Please ☑ the appropriate box and specify if applicable

Please affix label here

CLINICAL INFORMATION

Infection Precaution:
☐Standard ☐Contact ☐Droplet ☐Airborne

Allergy History:
☐No ☐Yes (please specify _____)

Asthma: ☐No ☐Yes

Diabetes Mellitus: ☐No ☐Yes

On Metformin: ☐No ☐Yes, stop 24 hours before IV contrast examination

LMP
Date: _____ (dd-mm-yyyy)/*Pregnant /*Menopause

Arrived with:
☐No assistive tools ☐Wheelchair ☐Stretcher

Clinical Information/Diagnosis:

☐Routine
☐Urgent
☐Portable (for plain X-ray only)

REFERRING DOCTOR'S DETAILS

Dr. _____

Address: _____

Tel: _____ Fax: _____

Signature Date

_____ _____

APPOINTMENT DATE & TIME

Date
_____ - _____ - _____ (dd-mm-yyyy)

Time
_____:_____ (hh:mm)

REQUEST EXAMINATION

☐**PLAIN X-ray**

_____

☐**ULTRASOUND**

_____

OGD / Colonoscopy Date & Time (if any)

_____ (dd-mm-yyyy) _____:_____ (hh:mm)

☐**COMPUTED TOMOGRAPHY**
☐Plain ☐Contrast
☐Plain + Contrast
Any implantable devices: ☐No ☐Yes

☐**MAGNETIC RESONANCE IMAGING**
☐Plain ☐Contrast
☐Plain + Contrast
Any implantable devices: ☐No ☐Yes

☐**OTHERS (PLEASE SPECIFY)**

Should you have any query, please contact us at 39466533

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