A1 IMAGING
一目醫學影像

MRI REQUEST FOR EXAMINATION FORM

T: 2116 9287 F: 3797 6286 E: enquiry@a1.hk W: https://A1.HK

Appointment: DATE TIME

★*Please arrive 30 minutes before your appointment and bring this form.*

PATIENT INFORMATION		REFERRING CLINICIAN
Last Name	First Name	Doctor's Name
Address	Date of Birth	Clinic Name & Address
	Phone#	
	Email	

CLINICAL INFORMATION	Phone#	Date
	PAYMENT METHOD	**REPORT AND FILM**
	☐ On Account	☐ Send to Referrer
	☐ Medical Card	☐ Collect by Patient
	☐ Pay by Patient	

MRI EXAMINATION (Please tick as appropriate) ☐ PLAIN ☐ WITH CONTRAST ☐ OPTIONAL

BRAIN

- ☐ Brain
- ☐ Brain + MRV Brain
- ☐ Brain + MRA Brain + MRV Brain
- ☐ Brain + MRA Brain + MRA Neck
- ☐ MRA Brain
- ☐ MRA Neck
- ☐ MRA Brain + MRA Neck
- ☐ MRV Brain
- ☐ Brain + MR Spectroscopy (1 lesion)
- ☐ MR Spectroscopy (per lesion)
- ☐ Brain + Pituitary Gland
- ☐ Pituitary Gland
- ☐ Brain + IAM
- ☐ Brain + MRA Brain
- ☐ Brain + Orbits
- ☐ Brainstem
- ☐ Stroke Package (Plain)
- ☐ Stroke Package (Plain Brain + Contrast MRA)
- ☐ Stroke Package (Contrast Brain + Contrast MRA)

HEAD & NECK

- ☐ Orbits
- ☐ Nasopharynx
- ☐ Oropharynx
- ☐ Oral Cavity & Tongue
- ☐ Hypopharynx & Larynx
- ☐ Paranasal Sinuses
- ☐ Salivary Glands
- ☐ Face
- ☐ IAM
- ☐ TMJ (Bilateral)
- ☐ Soft Tissue Neck
- ☐ Brain + IAM
- ☐ Brain + Nasopharynx
- ☐ Pulsatile Tinnitus Screening

MUSCULOSKELETAL

Extremities

- ☐ Arm ☐ R ☐ L
- ☐ Forearm ☐ R ☐ L
- ☐ Hand ☐ R ☐ L
- ☐ Finger _____ ☐ R ☐ L
- ☐ Thigh ☐ R ☐ L
- ☐ Leg ☐ R ☐ L
- ☐ Foot ☐ R ☐ L
- ☐ Toe _____ ☐ R ☐ L
- ☐ Soft tissue _____
- ☐ Branchial Plexus ☐ R ☐ L

Joints

- ☐ Shoulder ☐ R ☐ L
- ☐ Elbow ☐ R ☐ L
- ☐ Wrist ☐ R ☐ L
- ☐ Hip ☐ R ☐ L
- ☐ Both Hips (AVN Screening)
- ☐ Knee ☐ R ☐ L
- ☐ Ankle ☐ R ☐ L

SPINE

- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Sacrum & Coccyx
- ☐ Whole Spine Sagittal Screening (T1W + STIR)
- ☐ Ankylosing Spondylitis Package (Whole Spine Sagittal Screening + SIJs)

SCREENING PACKAGE

- ☐ Hypertension Screening
- ☐ Whole Body (Excluding Limbs)
- ☐ Whole Body (Excluding Limbs) + MRA Whole Body

BODY IMAGING

- ☐ Both Breasts (full diagnostic set)
- ☐ Both Breast Implants Integrity
- ☐ Both Breasts + Breast Implants integrity
- ☐ Single Breast ☐ R ☐ L
- ☐ Single Breast and Chest wall
- ☐ Thorax
- ☐ Upper Abdomen
- ☐ Upper Abdomen (Hepatospecific contrast)
- ☐ Upper Abdomen + Pelvis
- ☐ MRCP
- ☐ MRCP + Upper Abdomen
- ☐ Pelvis
- ☐ Prostate Gland
- ☐ Scrotum
- ☐ Rectum
- ☐ Perianal Assessment (FIA)

VASCULAR

- ☐ MRA Pulmonary Arteries
- ☐ MRA Thoracic Aorta
- ☐ MRA Abdominal Aorta
- ☐ MRA Whole Body
- ☐ MRA Whole Body + MRA Brain
- ☐ MRV (each region)

OTHERS

SAFETY SCREENING

Body Weight _____*(kg)*

	YES	NO
Have you had a previous MRI?	☐	☐
Has metal ever gone into your eye?	☐	☐
Do you have diabetes?	☐	☐
Do you have any kidney disease?	☐	☐
Are you on dialysis?	☐	☐
Are you claustrophobic?	☐	☐

If you have diabetes, renal problem, on dialysis or > 70 y.o., please provide your Creatinine/GFR within 1 month:

Creatinine _____ GFR _____

Date _____ *(dd/mm/yyyy)*

Do you have any of the following?	YES	NO
Aneurysm Clips	☐	☐
Artificial Cardiac Valve	☐	☐
Cardiac Pacemaker	☐	☐
Cochlear Implants	☐	☐
Coils/Stents	☐	☐
Neurostimulator	☐	☐
Retained Pacing Wires	☐	☐
Shrapnel/Bullets	☐	☐
Other implanted devices	☐	☐

If YES to any, please specify (*date, type, implant model*):

For female patient, date of your *Last Menstrual Period:*

Date _____ *(dd/mm/yyyy)*

PREVIOUS RELEVANT EXAMS

Please state ***when*** and ***where*** for each exam.

None	☐
MRI	☐ _____
CT	☐ _____
X-ray	☐ _____
Ultrasound	☐ _____
PET	☐ _____
Others	☐ _____

_____

_____

_____

★***Please bring the film/DVD of relevant previous scan.***

LIST ALL SURGERY

Please list all surgeries and specify a ***date*** and ***type***.

(DD/MM/YYYY)

(DD/MM/YYYY)

(DD/MM/YYYY)

(DD/MM/YYYY)

★***Please provide all surgical reports upon request***

For official use

Technologist:

_____/_____

LOCATION

Address: Unit 502, 5/F, Hing Wai Building, 36 Queen's Road Central, Central, Hong Kong