



# 仁濟醫院董事局伍時就磁力共振中心

## Yan Chai Hospital Board Ng Shi Chow MRI Centre

荃灣 香港 新界 荃灣 仁濟街 7-11號 仁濟醫院 B座 2字樓 280室  
Tsuen Wan Rm 280 2/F Block B Yan Chai Hospital 7-11 Yan Chai St Tsuen Wan NT HK

☎ 2419 7233  
☎ 2419 2722

### MRI Referral Form

No.

Patient's Name

Date of Birth   Male  Female

HKID No.

Tel. No.  Body Weight  Kg

Appointment Date / Time   AM  PM

Transport Need  Wheel chair  Stretcher  Others

Payment Method  By Patient  Cash  Credit Card

On Doctor's Account

Applicable to Hospital Referral (Or put Patient's Information Label here)

Referring Hospital

Ward / Dept.

Bed No.

Referring Doctor

Address

Doctor's Tel. No.

Medical History	Yes	No		Yes	No		Yes	No
Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker / Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Has the patient been exposed to metallic fragments at work?	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Electrodes	<input type="checkbox"/>	<input type="checkbox"/>	Metallic Foreign Body (e.g. bullet)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Brain Clips / Vascular Clips	<input type="checkbox"/>	<input type="checkbox"/>	Pls specify region <input type="text"/>		
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Shunts	<input type="checkbox"/>	<input type="checkbox"/>			
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Neuro-stimulators	<input type="checkbox"/>	<input type="checkbox"/>	Permanent Eyeliner Tattoos	<input type="checkbox"/>	<input type="checkbox"/>
Last Menstrual Period <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insulin-pump	<input type="checkbox"/>	<input type="checkbox"/>	Dentures	<input type="checkbox"/>	<input type="checkbox"/>
Previous Operations <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Implanted Perfusion Pump	<input type="checkbox"/>	<input type="checkbox"/>	I.U.C.D.	<input type="checkbox"/>	<input type="checkbox"/>
<b>Allergy History</b>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aids / Devices	<input type="checkbox"/>	<input type="checkbox"/>	Metal Mesh	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cochlear Implants	<input type="checkbox"/>	<input type="checkbox"/>	Wire Sutures	<input type="checkbox"/>	<input type="checkbox"/>
Previous Contrast Reaction	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Shrapnel / Metallic Fragments	<input type="checkbox"/>	<input type="checkbox"/>
Drug Allergy <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metallic Rods / Pins / Screws / Nails	<input type="checkbox"/>	<input type="checkbox"/>	Life Support System	<input type="checkbox"/>	<input type="checkbox"/>
Others <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>			

**Clinical Diagnosis**

Examination Requested			
Head & Neck	Musculoskeletal	Spine	Body
<input type="checkbox"/> Brain	<input type="checkbox"/> Shoulder ( R / L )	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Thorax
<input type="checkbox"/> Sella / Pituitary	<input type="checkbox"/> Elbow ( R / L )	<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Upper Abdomen
<input type="checkbox"/> Brain Stem	<input type="checkbox"/> Wrist ( R / L )	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Pelvis
<input type="checkbox"/> Skull Base	<input type="checkbox"/> Knee ( R / L )		<input type="checkbox"/> Prostate
<input type="checkbox"/> Orbits	<input type="checkbox"/> Ankle ( R / L )	<b>MR Angiography</b>	<input type="checkbox"/> MRCP
<input type="checkbox"/> IAM	<input type="checkbox"/> Hip ( R / L )	<input type="checkbox"/> MRA (Brain)	<input type="checkbox"/> Kidneys
<input type="checkbox"/> Nasopharynx	<input type="checkbox"/> Sacrum	<input type="checkbox"/> MRA (Neck/Carotid Arteries)	<input type="checkbox"/> Perineum
<input type="checkbox"/> Paranasal Sinuses	<input type="checkbox"/> SI Joints	<input type="checkbox"/> MRA (Renal)	
<input type="checkbox"/> T-M Joints	<input type="checkbox"/> Pelvic Bone	<input type="checkbox"/> MRV (Brain)	
<input type="checkbox"/> Neck / Thyroid			
<input type="checkbox"/> Others <input type="text"/>	<input type="checkbox"/> Others <input type="text"/>	<input type="checkbox"/> Others <input type="text"/>	<input type="checkbox"/> Others <input type="text"/>
<input type="checkbox"/> Plain Study Only	<input type="checkbox"/> Contrast Study Only	<input type="checkbox"/> Plain & Contrast	<input type="checkbox"/> Optional

Report  Patient to collect  
 Send / Fax to

Signature of Referring Doctor  Date

\* Please remind the patients to bring along their previous X-Ray and other scan films.  
MF3 (JUN 10)

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## 前往方法



**港鐵** 於港鐵荃灣站下車(B出口)  
於港鐵荃灣西站可轉乘 95K 到港鐵荃灣站

**巴士** 39A、48X、49X、59X、66、67M、68A、69M、265M、269M、278X  
於港鐵荃灣站停車場大廈外，或於荃灣城市廣場 2 期外下車  
57M、59M、60M、66M、68M、243M  
於港鐵荃灣站下車

**小巴** 81、409、409K 於荃灣城市廣場 2 期外，或於荃灣街市下車

(按以上各路線下車後，步行約 10 至 15 分鐘)

## 病人前往檢查前注意事項

1. 請攜同此表格準時到達本中心。
2. 請攜帶所有舊 X 光片或舊掃描片。
3. 如有查詢、改期或取消預約，請於辦公時間內致電本中心。

## 辦公時間

星期一至五	上午九時至下午五時
星期六	上午九時至下午一時
星期日及公眾假期	休息