

Patient's Name: _____ Date: _____

Clinical Diagnosis: _____

Examination(s) Request: _____

Date: _____

Lab No.: _____

(For Office use only)

Referring Doctor		Clinic Address and Dr. Signature / Company Chop
Tel	Fax	
Clinical Diagnosis		

Patient's History of Allergy
No / Yes (please specify) _____ L.M.P. _____

Patient's Name 病人姓名 _____ Date of Birth 出生日期 _____

Gender 性別 _____ HKID No. 身份証號碼/
Passport No. 護照號碼 _____ Examination Date 檢查日期 ____ (dd) / ____ (mm) / ____ (yy)
Examination Time 檢查時間 _____ am / pm

PLEASE SPECIFY OR PUT AN " ✓ " IN THE BOXES BELOW

DIGITAL X-RAY

- X-RAY Examination
 CXR Abdomen Pelvis
 KUB Others: _____
 Spine: Lumbar / Thoracic / Cervical
View(s): _____
 Special Radiological Examination
Please specify region(s): _____

BONE DENSITOMETRY DEXA

- Bone Densitometry (Whole Body)
 Bone Densitometry (Lumbar Spine & Femur)
 Body Composition Analysis
 Bone Densitometry (Whole Body) & Body Composition Analysis
 Bone Densitometry (Lumbar Spine & Femur) & Body Composition Analysis

ULTRASOUND EXAMINATIONS

- Please specify region(s): _____

DIGITAL MAMMOGRAPHY

- Mammogram (One side only) Mammogram & U/S Breasts (Both sides)
 Mammogram (Both sides) Breast Ductography
 Sterotactic/Ultrasound Guide Biopsy

COMPUTED TOMOGRAPHY

Examination(s) Requested

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Pelvimetry | <input type="checkbox"/> Spine: Lumbar / Thoracic / Cervical | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Extremities | <input type="checkbox"/> Pelvis | Level _____ to _____ | <input type="checkbox"/> Calcium Score |
| <input type="checkbox"/> Facial Bones | <input type="checkbox"/> Petrous Temporal Bones | <input type="checkbox"/> Angiography | <input type="checkbox"/> Coronary Angiography |
| <input type="checkbox"/> Larynx | <input type="checkbox"/> Pituitary Fossa | <input type="checkbox"/> Brain <input type="checkbox"/> Carotid Artery | <input type="checkbox"/> Calcium Score +
Coronary Angiography |
| <input type="checkbox"/> Nasopharynx | <input type="checkbox"/> Thorax | <input type="checkbox"/> Brain & Neck <input type="checkbox"/> Abdomen | Contrast Medium
<input type="checkbox"/> Plain Only
<input type="checkbox"/> Contrast Only
<input type="checkbox"/> Plain & Contrast
<input type="checkbox"/> Plain & Optional Contrast |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Lower Limb <input type="checkbox"/> Others | |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> Sacrum & Sacro-Iliac Joints | <input type="checkbox"/> Colonoscopy | |
| <input type="checkbox"/> Paranasal Sinuses | <input type="checkbox"/> Upper Abdomen | <input type="checkbox"/> Urography | |
| <input type="checkbox"/> Parotids | <input type="checkbox"/> Upper Abdomen & Pelvis | | |

DELIVERY MATERIAL

- Film
 CD Rom
 Film+CD Rom (additional charge HK\$100)
 Others: _____

DELIVERY OF FILM & REPORT

- Send to Doctor
 Fax to Doctor (report only)
 Pick up by patient

PAYMENT METHOD

- Cash
 On account

REMARKS

Mon. - Fri. 星期一至五 9:00am - 6:30pm
Sat. 星期六 9:00am - 1:00pm

Closed on Sun. & Public Holiday
星期日及公眾假期休息

12/F, Oterprise Square, 26 Nathan Road,
Tsim Sha Tsui

(TST MTR Exit C1 / KCR Exit K)

Entrance at Middle Road (Opposite to Sheraton Hotel)

尖沙咀彌敦道26號東企業廣場12樓

(尖沙咀地鐵站C1出口 / 東鐵K出口)

請用中間道入口 (喜來登酒店對面)

Tel 電話: 852 • 2739 3111

Fax 傳真: 852 • 2739 6111

Email 電郵: enquiry@ddchealth.com

Website 網址: www.ddchealth.com



IMPORTANT NOTES 重要事項

Please make appointment and bring along old films for comparison. 敬請預約及帶回舊片。
Please notify us for any change or cancellation of this appointment. 如需更改或取消預約，請盡早通知本中心。

For Ultrasound Examinations 超聲波檢查

Examination 檢查項目	Preparation 準備事項
Abdomen / Upper Abdomen 腹部及上腹	Fasting 6 hours before examination is required 檢查前空腹6小時
Gallbladder 膽囊	Fasting 4 hours before examination is required 檢查前空腹4小時
Kidneys, Bladder, Pelvis, Transrectal Prostate, Gynaecology, Transvaginal Gynaecology Scan, Obstetrics 腎臟、膀胱、盆腔、前列腺(經直腸掃描)、婦科、 婦科(經陰道掃描)、產科	A full bladder is needed during the examination 檢查前喝6杯開水讓膀胱膨脹

For Computed Tomography (CT) 電腦掃描

Examination 檢查項目	Preparation 準備事項
IV Contrast Study 接受造影劑注射	Fasting 4 hours before examination is required 檢查前空腹4小時