5 Lower Kent Ridge Road, Singapore 119074
Tel: (65) 6779 5555, Fax: (65) 6779 5678
Department of Diagnostic Imaging
Tel: (65) 6772 5201, Fax: (65) 6772 5219
Enquiry: ddi_enquiries@nuhs.edu.sg

Precautionary Alerts

NATIONAL UNIVERSITY HOSPITAL

Department of Diagnostic Imaging

To be completed by Requesting Doctor — IMAGING REQUEST FORM

Name:
NRIC No:
Birth Date:
Sex: ☐ **Male** ☐ **Female**
Contact No:

Affix patient label

Ordering Instructions:

Please **complete** the screening **checklist(s)** on **Page 2** if you are requesting for any of the following examinations:

- **MRI Scan**
- **CT Scan**
- **Contrast-enhanced procedures (e.g. IVU)**
- **Interventional Radiology procedures**

Type: ☐ **Inpatient (Ward/Bed: _____)**
☐ **Outpatient** **Class:** ☐ **PTE** ☐ **SUB**
Transport Mode:
Preferred Date of Exam: ☐ **Wheelchair** ☐ **Trolley**
Follow- Up Appointment(TCU): ☐ **Walking** ☐ **Portable**
Referring Institution: *(NUH downtime only)*
Contact no:

Investigations Requested:

Priority: Routine / Early / **STAT**

Clinical Diagnosis:

Relevant History & Examination:

Allergy:

Medical Alerts:

Requestor: **Consultant:**

MCR No.: **Date of Request:** **MCR No.:**

To be completed by Patient — PATIENT DECLARATION

a) *Pregnancy declaration: ☐ Pregnant ☐ Not pregnant *LMP Date: _____ **for female patients only*

b) I confirm that my particulars and above declaration are correct.

Patient's Signature: **Date:**

To be completed by Radiology Department Use Only

Appointment Date/ Time:
Radiographer:
Radiologist Instruction/ Notes:

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To be completed by Requesting Doctor **SCREENING CHECKLIST**

☐ MRI Scan

MRI Risk Factors

Please complete this checklist

Yes	No	
☐	☐	Pacemaker, Artificial Heart Valve, Electrodes
☐	☐	Brain / Aneurysm clips, Neurostimulators, Hearing aids / Ear Implants, Permanent eyeliner tattoos
☐	☐	Vascular access port / catheter
☐	☐	Prosthesis, ORIF, Metal mesh, Wire sutures / clips, Metallic stent / filter /coil, IUCD
☐	☐	Implanted drug infusion device, Magnetically-activated implant or device
☐	☐	Shrapnel / metallic foreign body
☐	☐	Exposed to metal fragments at work
☐	☐	Possibility of metal fragments in the eyes
☐	☐	Other metal, electronic implant or devices in the body
☐	☐	Claustrophobia, Breathing problem, Movement disorder
☐	☐	Weighs more than 120 kg

☐ CT Scan / Other contrast-enhanced procedures (e.g. IVU)
☐ Interventional Radiology

Contrast Risk Factors for

Interventional Radiology Procedures / Contrast- enhanced Procedure (CT/ IVU)

Yes	No		**If Yes, please adhere to the following recommendations**
☐	☐	Metformin Medication	Patient should stop taking Metformin on the day of the examination and resume 48 hours later.
☐	☐	Asthma	Prescribe: **30 mg Prednisolone** to be taken on the **night before** **30 mg Prednisolone** on the **morning** of the examination
☐	☐	Multiple drug allergies	
☐	☐	Any History of Renal Dis ease or Dialysis Indicate next dialysis date: _____	Perform Renal Panel test and specify Creatinine Level **Creatinine Level:** _____ **Date of Last Test:** _____ (NOTE: *Alert Radiologist if contrast scan is required and Creatinine level is > 30 mg/dl)*

For <u>all Interventional Radiology/</u>, please specify the following:

PT :_____ (12.0-14.5 sec)
INR :_____ (1.2-1.4)
Platelets (Plts) :_____ ((132 – 372 x 10^9 /L)
PTT :_____ (27.0-35.6 sec)
Creatinine (Cr) :_____ (65-125umol/L)