**_Please adhere Patient Label_**
**_PATIENT DETAILS:_**

matilda
International Hospital
明 德 國 際 醫 院

41, Mount Kellett Road, The Peak, Hong Kong
Tel: 2849 1540 Fax: 2849 2572

Office Hour: Monday to Friday 0800-1700 Saturday 0800-1300 After Office Hour, additional Charges will be applied

# CT Coronary Request Form

Date: ____________ Time: ____________

☐ Calcium Score
☐ CT Coronary Angiogram
☐ Ca Score + Coronary Angiogram
☐ Ejection Fraction
☐ Echocardiogram
☐ Others ____________

## Patient's Cardiac History

Reported By ☐ Cardiologist ☐ Radiologist

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Smoking |
| ☐ | ☐ | Hypertension |
| ☐ | ☐ | Hyperlipidaemia if Yes, please state Total Cholestrol ______ HDL ______ LDL ______ TG ______ |
| ☐ | ☐ | Family History of Coronary Heart Disease. If Yes, please indicate ☐ Mother ☐ Father ☐ Sibling |
| ☐ | ☐ | Personal History of Coronary Heart Disease |
| ☐ | ☐ | Typical chest pain |
| ☐ | ☐ | Diabetic Mellitus |
| ☐ | ☐ | Previous heart scan If yes, please give result |
| ☐ | ☐ | Cardiovascular Medications If yes, please specify |

____________

## Clinical Data & Diagnosis

(Please bring along old films and/or report for comparison)

| | |
|---|---|
| Standard Precaution | ☐ |
| Contact Precaution | ☐ |
| Droplet Precaution | ☐ |

## Medical History

(To be completed for patient required CT Coronary Angiogram):

| Yes | No | |
|---|---|---|
| ☐ | ☐ | History of reaction to previous contrast injection (specify) ____________ |
| ☐ | ☐ | History of asthma |
| ☐ | ☐ | History of other allergies (specify) ____________ |
| ☐ | ☐ | History of Diabetes Mellitus |
| ☐ | ☐ | History of kidney disease |
| ☐ | ☐ | For patients aged > 60 years, please provide renal function: Creatinine: ______ umol / L Urea: ______ umol / L |
| ☐ | ☐ | Heart Block |
| ☐ | ☐ | Any medicine for treatment of erectile dysfunction up to 1 week ago (It will affect the function of nitrolingual spray) |
| ☐ | ☐ | Any known contraindication to Beta-blocker (Metoprolol)? |

Patient need to fast 4 hours before the procedure

## Department Use:

CT No.:

Operator:

Radiologist / Cardiologist:

LMP: ____________

Chance of pregnancy:
☐ YES ☐ NO

☐ **Bill Patient** ☐ **Bill Doctor**

Signed & Print Dr's Name: ____________

*Compiled by Imaging Centre (IC)*
*Revised by IC*
*Approved by Joanna Lo*
*Revision 7 (January 2017)*

*Effective since 2013*