

Appointment Date & Time: _____

Patient's Name: _____ HKID no.: _____

Contact no.: _____ Gender: _____ Age: _____ Report: ☐ Send to clinic ☐ Collect by Patient

Referral Doctor: _____ Payment: ☐ Cash ☐ Medical Card ☐ On Account

Clinical Information:

- ☐ Implant: _____ ☐ Allergies: _____ ☐ LMP: _____
- ☐ Renal Disease : Creatinine level _____ umol/L (Date: _____) eGFR : _____
- ☐ Pacemaker ☐ Asthma ☐ Hypertension ☐ Diabetes Mellitus ☐ Pregnant ☐ Claustrophobia

Exam(s): ☐ Plain ☐ Plain + Contrast ☐ Optional

BRAIN, HEAD & NECK	JOINT	BODY
<input type="checkbox"/> Stroke Package <input type="checkbox"/> Brain <input type="checkbox"/> Brain + MRA <input type="checkbox"/> Sella / Pituitary <input type="checkbox"/> Orbits <input type="checkbox"/> IAMs <input type="checkbox"/> Neck <input type="checkbox"/> Nasopharynx / TMJ <input type="checkbox"/> Salivary Gland <input type="checkbox"/> Paranasal Sinuses <input type="checkbox"/> Parotid / Submandibular	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Feet <input type="checkbox"/> _____	<input type="checkbox"/> Thorax <input type="checkbox"/> Upper Abdomen <input type="checkbox"/> Whole Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Prostate <input type="checkbox"/> Urogram <input type="checkbox"/> MRCP <input type="checkbox"/> Breasts <input type="checkbox"/> Hypertension Package

MR ANGIOGRAPHY	SPINE	OTHERS
<input type="checkbox"/> Thoracic MRA <input type="checkbox"/> Abdominal MRA <input type="checkbox"/> Lower Abdominal Aorta + Lower Limbs Angiograms <input type="checkbox"/> Venogram _____	<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Whole Spine <input type="checkbox"/> Sacrum / Coccyx <input type="checkbox"/> SI Joints <input type="checkbox"/> Whole Spine Sagittal Screening	<input type="checkbox"/> FibroScan



Address:

G/F, Shop 3 Hotel COZI Resort, 4 Kin Fung Circuit,
Tuen Mun

Opening Hours:

Monday to Friday 9 a.m. - 6 p.m.
Saturday 9 a.m. - 1 p.m.

Tel: 21539900

Fax: 21539022

Email: info@insta-imaging.com.hk

Website : www.insta-imaging.com.hk

Please call for an appointment

地址:

屯門建豐街 4 號悅品度假酒店地下 3 號鋪

辦公時間:

星期一至五 9 a.m. - 6 p.m.
星期六 9 a.m. - 1 p.m.

電話：21539900

傳真：21539022

電郵： info@insta-imaging.com.hk

網站： www.insta-imaging.com.hk

敬請致電預約