MRI REFERRAL REQUISTION

ST. THOMAS RADIOLOGY ASSOCIATES

St. Thomas Radiology Associates, LLC

9149 Estate Thomas
Paragon Medical Building, Suite 103
St. Thomas, U.S. Virgin Islands 00802
Phone: (340) 774-0265 · Fax: (340) 776-0228
www.stthomasrad.com

Yuri Peterkin, M.D.
Mahagony Ambrose, M.D.

Patient Name: _____ **Date of Birth:** _____ ☐ **Male** ☐ **Female**

Clinical Information / Diagnosis or Symptoms (Please do not use R/O) _____

_____

_____

☐ **BRAIN**
☐ w/o contrast ☐ w/without contrast

☐ **INTERNAL AUDITORY CANALS**
☐ w/without contrast

☐ **PITUITARY**
☐ w/without contrast

☐ **ORBITS**
☐ w/without contrast

☐ **CHEST**
☐ w/without contrast

☐ **BREAST**
☐ w/without contrast

☐ **SOFT TISSUE NECK**
☐ w/o contrast ☐ with contrast
☐ w/without contrast

☐ **CERVICAL SPINE**
☐ w/o contrast ☐ w/without contrast

☐ **THORACIC SPINE**
☐ w/o contrast ☐ w/without contrast

☐ **LUMBAR SPINE**
☐ w/o contrast ☐ w/without contrast

☐ **SACRUM OR COCCYX**
☐ w/o contrast ☐ w/without contrast

☐ **ABDOMEN**
☐ w/without contrast

☐ **MRCP**
☐ without contrast

☐ **PELVIS**
☐ w/o contrast ☐ w/without contrast

EXTREMITY:

☐ Shoulder **R** ☐ or **L** ☐
☐ Humerus **R** ☐ or **L** ☐
☐ Elbow **R** ☐ or **L** ☐
☐ Wrist **R** ☐ or **L** ☐
☐ Hand **R** ☐ or **L** ☐
☐ Thumb/ Finger **R** ☐ or **L** ☐
☐ Hip **R** ☐ or **L** ☐
☐ Thigh/ Femur **R** ☐ or **L** ☐
☐ Knee **R** ☐ or **L** ☐
☐ Lower leg TIB/FIB **R** ☐ or **L** ☐
☐ Ankle **R** ☐ or **L** ☐
☐ Foot **R** ☐ or **L** ☐

MR ANGIOGRAPHY:

☐ **Brain** w/o contrast
☐ **Carotids** with contrast
☐ **Renals** with contrast
☐ **Peripherals/Legs/Runoff**
☐ w/without contrast

Other: _____

***PLEASE NOTE, CANCER PATIENTS SHOULD HAVE MRI OF HEAD/CHEST/ABDOMEN/SPINE WITH AND WITHOUT CONTRAST**

- Please report approximately 15-20 minutes prior to appointment
- Please bring X-rays or CT scans if you have them.
- Please be sure to bring your insurance card.
- If you are unable to keep your appointment, please notify us 24 hours in advance, if possible.
- The examination will take apporoximately 1 hour.

Print Clinician Name: _____

Sign Clinician Name: _____ **Date:** _____

PROCEDURE REFERRAL REQUISTION

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Clinical Information / Diagnosis or Symptoms (Please do not use R/O) _____

_____

_____

MUSCULOSKELETAL PROCEDURES

☐ **Anesthetic and Steroid JOINT Injection:** (specify site) _____ **R** ☐ or **L** ☐ or **BIL** ☐

☐ **Anesthetic and Steroid BURSA Injection:** (specify site) _____ **R** ☐ or **L** ☐ or **BIL** ☐

☐ **Anesthetic and Steroid TENDON SHEATH Injection:** (specify site) _____ **R** ☐ or **L** ☐ or **BIL** ☐

☐ **Anesthetic and Steroid NERVE SHEATH Injection:** (specify site) _____ **R** ☐ or **L** ☐ or **BIL** ☐

☐ **Joint Aspiration:** (specify site) _____ **R** ☐ or **L** ☐ or **BIL** ☐

☐ **Soft Tissue Fluid Collection Aspiration:** (specify site) _____

☐ **Soft Tissue Mass Biopsy:** (specify site) _____

☐ **CT Guided Bone Biopsy:** (specify site) _____

☐ **CT Guided Lumbar Epidural Steroid Injection**

☐ **CT Guided Nerve Root Block**

☐ **CT Guided Facet Joint Anesthetic and Steroid Injection**

☐ **CT Guided Sacroiliac Joint Anesthetic and Steroid Injection**

☐ **Carpal Tunnel Injection**

☐ **Trigger Finger Injection**

☐ **CT/MR Arthrogram**
Joint: _____

OTHER PROCEDURES

☐ **Ultrasound Guided Thyroid Biopsy**

☐ **Ultrasound Guided Soft Tissue Biopsy** _____

☐ **Varicose Vein Ablation**

☐ **Fine Needle Aspiration:** (specify site) _____

☐ **CT Guided Biopsy:** (specify site) _____

☐ **CT Guided Drainage:** (specify site) _____

☐ **CT Guided Paracentesis**

WOMEN"S HEALTH

☐ **Ultrasound Guided Breast Biopsy**

☐ **Stereotactic Breast Biopsy**

☐ **Breast Localization**
US ☐ or **MAMMO** ☐

☐ **Breast / Cyst Aspiration**

☐ **Uterine Fibroid Embolization**

Print Clinician Name: _____

Sign Clinician Name: _____ **Date:** _____