RADIOLOGY REFERRAL REQUISTION

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) _____

_____

_____

HEAD:

- ☐ Skull
- ☐ Sinuses
- ☐ Mastoids
- ☐ Mandible
- ☐ Facial Bones
- ☐ Nasal Bones
- ☐ TMJ

ABDOMEN:

- ☐ KUB
- ☐ Upright KUB
- ☐ Esophagram
- ☐ UGI
- ☐ SM Bowel Series
- ☐ BE
- ☐ BE w/Air Contrast
- ☐ IVP
- ☐ VCUG

CHEST:

- ☐ PA
- ☐ PA & LAT
- ☐ LAT
- ☐ 4 View Chest
- ☐ LAT Decubitus
- ☐ Sternum
- ☐ Clavicle
- ☐ Ribs

EXTREMITY:

- ☐ Scapula R ☐ or L ☐
- ☐ Shoulder R ☐ or L ☐
- ☐ Humerus R ☐ or L ☐
- ☐ Elbow R ☐ or L ☐
- ☐ Forearm R ☐ or L ☐
- ☐ Wrist R ☐ or L ☐
- ☐ Hand R ☐ or L ☐
- ☐ Pelvis R ☐ or L ☐
- ☐ Hip R ☐ or L ☐
- ☐ Femur R ☐ or L ☐
- ☐ Knee R ☐ or L ☐
- ☐ TIB/FIB R ☐ or L ☐
- ☐ Ankle R ☐ or L ☐
- ☐ Foot R ☐ or L ☐
- ☐ Heel R ☐ or L ☐
- ☐ Toes R ☐ or L ☐
- ☐ Finger R ☐ or L ☐

ULTRASOUND:

- ☐ Neuro-Head
- ☐ Abdominal
- ☐ Gall Bladder
- ☐ Renal
- ☐ Aorta
- ☐ Prostatic-Transrectal
- ☐ Thyroid
- ☐ Testicular
- ☐ Extremity-Non-Vascular
- ☐ Endovaginal

- ☐ **UTERINE FIBROID EMBOLIZATION**
- ☐ **SKINNY NEEDLE ASPIRATION BX**
  Organ _____

SPINE:

- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar

VASCULAR STUDIES:

- ☐ DVT-Lower Ext. R ☐ or L ☐
- ☐ DVT-Upper Ext. R ☐ or L ☐
- ☐ Arterial Doppler-Lower Ext.
- ☐ Arterial Doppler-Upper Ext.
- ☐ Arterial Bypass Graft
- ☐ Abdominal Doppler
- ☐ Carotid Doppler
- ☐ Hemodialysis Access Doppler
- ☐ Abdomen/Pelvic or Scrotal Doppler
- ☐ 980 EVLT R ☐ or L ☐
- ☐ Varicose Vein Evaluation (73971 & 93965)

WOMEN"S HEALTH:

- ☐ Mammogram
- ☐ Breast Ultrasound
- ☐ Image Guided Breast Biopsy
- ☐ Pelvic Ultrasound
- ☐ OB Ultrasound
- ☐ OB Limited
- ☐ BPP
- ☐ OB Limited and BPP
- ☐ Bone Densitometry (DEXA)
- ☐ HSG
- ☐ Stereotactic Biopsy
- ☐ Image Guided Aspiration Area/Origin
- ☐ Breast Localization ☐ Ultrasound ☐ Mammo

Print Clinician Name: _____

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

CT SCAN REFERRAL REQUISTION

ST. THOMAS RADIOLOGY ASSOCIATES

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

_____

_____

☐ **HEAD**
☐ w/o contrast ☐ w/without contrast

☐ **HEAD & SINUSES**
☐ w/o contrast ☐ w/without contrast

SELLA TURCICA, EAR, ORBIT
☐ w/o contrast ☐ w/without contrast

☐ **MAXILLOFACIAL, SINUS**
☐ w/o contrast ☐ w/without contrast

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

☐ **CHEST**
☐ w/o contrast ☐ with contrast
☐ w/without contrast

☐ **ABDOMEN**
☐ w/o contrast ☐ with contrast
☐ w/without contrast

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

☐ **ABDOMEN & PELVIS**
☐ w/o contrast ☐ with contrast
☐ w/without contrast

☐ **CHEST, ABDOMEN & PELVIS**
☐ w/o contrast ☐ with contrast
☐ w/without contrast

EXTREMITY:

☐ Shoulder **R** ☐ or **L** ☐ or **BIL** ☐
☐ Wrist **R** ☐ or **L** ☐ or **BIL** ☐
☐ Hip **R** ☐ or **L** ☐ or **BIL** ☐
☐ Knee **R** ☐ or **L** ☐ or **BIL** ☐
☐ Ankle **R** ☐ or **L** ☐ or **BIL** ☐
☐ Other **R** ☐ or **L** ☐ or **BIL** ☐
Specify: _____

SPINE:

☐ Cervical
☐ Thoracic
☐ Lumbar

CT ANGIOGRAPHY:

☐ CTA of Brain
☐ CTA of Neck
☐ CTA of Chest
☐ CTA of Pelvis
☐ CTA of Upper Extremity **R** ☐ or **L** ☐
☐ CTA of Lower Extremity **R** ☐ or **L** ☐
☐ CTA of Abdomen

ADDITIONAL VIEWS:

☐ Coronal, Sagittal, Multiplanar, Oblique, 3-D and/or Holographic reconstruction of CT ordered

Print Clinician Name: _____

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