ST.CROIXMRI

4500 Queen Mary HWY., Suite B4
Christiansted, St. Croix, U.S. Virgin Islands 00820
Phone: (340) 778-5840 · Fax: (340) 778-5844
www.radiology.vi

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MRI REFERRAL REQUISTION

Patient Name: _____ **Date of Birth:** _____

Phone Number: _____ ☐ **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

☐ **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

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

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

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

☐ **MRCP**
☐ without contrast

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

MR ANGIOGRAPHY:
☐ **Brain** w/o contrast
☐ **Carotids** with contrast
☐ **Renals** with contrast

☐ **UTILIZE CONTRAST PER RADIOLOGIST DISCRETION**

EXTREMITY:
☐ Shoulder R☐ or L☐
☐ Humerus R☐ or L☐
☐ Elbow R☐ or L☐
☐ Forearm 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/ Hindfoot R☐ or L☐
☐ Midfoot R☐ or L☐
☐ Forefoot R☐ or L☐

Other: _____

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

- Please report approximately 30 minutes prior to appointment time. **NO** Metal or jewelry can be worn in the machine.
- Please bring X-rays or CT scans if you have them.
- Please be sure to bring your insurance card and photo ID.
- If you are unable to keep your appointment, please notify us 24 hours in advance, if possible.
- The examination will take apporoximately 1 hour.
- Patient **MUST** notify us if they have a pacemaker, glucose monitor, hearing aid or any implanted device at time of scheduling.

Print Clinician Name: _____

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

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