



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 R or L
TIB/FIB

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: _____

ST. CROIX MRI



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