Telephone: 869-465-7384 WhatsApp: 869-669-7944
Email: mri@virscio.com Website: www.skb-mri.com
Address: Lower Bourryeau Estate, St.Kitts, W.I.

St. Kitts Biomedical MRI

Referral Form

☐ **Routine** ☐ **Urgent** ☐ **Send images with patient**

Patient's Name: _____ **DOB**: _____ **Age**_____

Patient's Tel.: _____ **Address**: _____

Referring Physician: _____ **Physician's Tel.:** _____

Physician's Email address: _____

Physician's Signature: _____ **Date**_____

Patient's clinical information, <u>Diagnosis Required</u>:

Exam Requested (specify or tick below):

Is contrast required? ☐ **Y** ☐ **N**

If yes, Serum Creatinine _____ Date Drawn _____

*Note: All contrast studies require a serum creatinine level that was done within the last 4 weeks. If this is not available, please arrange for it to be performed at the MRI facility for a fee.

D **Sedation Needed**

MRI-Magnetic Resonance Imaging

☐ Brain-Routine	☐ Pituitary	☐ Orbits (**with contrast**)
☐ IACs (**with contrast**)	☐ Soft Tissue Neck (**with contrast**)	☐ Seizure
☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Lumbar-sacral	☐ Abdomen (liver, kidneys, spleen)	☐ Pelvis -Routine
☐ Pelvis- Female Organs	☐ Pelvis-prostate	
☐ Shoulder ☐ **L** ☐ **R**	☐ Humerus ☐ **L** ☐ **R**	☐ Elbow ☐ **L** ☐ **R**
☐ Forearm ☐ **L** ☐ **R**	☐ Wrist ☐ **L** ☐ **R**	☐ Hand ☐ **L** ☐ **R**
☐ Hip ☐ **L** ☐ **R**	☐ Femur ☐ **L** ☐ **R**	☐ Knee ☐ **L** ☐ **R**
☐ Tibia/Fibula ☐ **L** ☐ **R**	☐ Ankle ☐ **L** ☐ **R**	☐ Foot ☐ **L** ☐ **R**

MRA-Magnetic Resonance Angiography

☐ Head (Circle of Willis)
☐ Carotids(with contrast)

MRV-Magnetic Resonance Venography

☐ Head (Cerebral Venography)