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## **Chest X-Ray**

Patient Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

DOB: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

### **Test Ordered:**

**2 View Chest X-Ray (71046)**

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NPI: \_\_\_\_\_