Chest X-Ray Requisition

Today's Date: _____ / _____ / _____

Patient Name: _____

Date of Birth: _____ / _____ / _____

Phone Number: (_____) _____ - _____

_____

Street Address City State Zip Code

Chest X-Ray Exam

Exam requested: Chest, PA, and Lateral

Exam Reason: TB Screening (Z11.1)

Physician Signature: _____

Send Results to

Stepworks
Fax: 859-298-3322
ATTN: Human Resources

Additional Copies: _____

Billing

Stepworks
P. O. Box 6209
Elizabethtown, KY 42702-6209
ATTN: Accounts Payable

For Radiology Use Only

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