

# X-Ray Requisition

Golden Valley Mobile Imaging

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PATIENT NAME: [REDACTED] DOB: [REDACTED]

DATE: [REDACTED]

FACILITY NAME: [REDACTED] ROOM NUMBER: [REDACTED]

ORDERING PHYSICIAN: [REDACTED]

NURSE: [REDACTED]

PRIORITY:  ROUTINE  STAT

BODY PART: [REDACTED]

SIDE: [REDACTED]

VIEWS: [REDACTED]

SYMPTOMS/DIAGNOSIS:  
[REDACTED]