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# X-RAY ORDER FORM

Patient Name:______________________________________________________ D.O.B.: ________________________

Appointment Date: ____________________________________________ Time:__________ ☐ am ☐ pm

Body part to be x-rayed: ________________________________________________________________________________

Views to be taken:______________________________________________________________________________________

Symptoms/Diagnosis:____________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

Physician's Signature: ___________________________________________________________________________________

Physician's name (printed):______________________________________________________________________________

Physician's NPI # _______________________________________________________________________________________

Films read by Mercy Radiologist ? ☐ Yes ☐ No

Films to be sent back with patient for ordering physician ? ☐ Yes ☐ No