



Steindler Orthopedic Clinic P.L.C.

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X-RAY ORDER FORM

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www.steindlerorthopedic.com

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