REQUEST FOR ADDITIONAL TESTING

Fax completed form to: 541-389-5723

Patient Name: _____

DOB: _____

Accession # (if known): _____

Date of Service (if known): _____

Send for: _____

Person Submitting Request/Contact: _____

Date of Request: _____

ICD10:_____.

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Requesting Physician printed name:

_____

Requesting Physician Signature:

_____

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