

**OKLAHOMA DEPARTMENT OF CORRECTIONS
RADIOGRAPHIC REPORT**

Examination Requested: Routine (Admission) Chest: <input type="checkbox"/> Other (Specify):		Facility Requesting Report:
No. of films:	Date Completed:	Requested By: (Provider)

Pertinent Clinical History, Operations, Physical Findings, Provisional Diagnosis:

Radiographic Review:

To be reviewed by Radiologist: ☐ Yes ☐ No

Signature of Provider

Date

Radiographic Report:

Signature of Radiologist

Date

Inmate Name: (Last, First)	ODOC #	DOB	Gender
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Original: Chart
Copy: Tracking

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