# *All India Institute of Medical Sciences, Jodhpur*

## *Department of Diagnostic And Interventional Radiology*

## ***PROTABLE X-RAY REQUISITION FORM***

***NAME:……Age/Sex:……Date:……Time……..***

***Patient ID……Ward/Bed No:……***

***Pregnancy if any (Yes/No)……Date of LMP……***

***Portable X-ray Billing No:……***

***Clinical History and Provisional Diagnosis:-***

***Reason for which Portable X-ray is Required:-***

***Clinician's Signature***

***Name and Designation***