** OL JABET HOSPITAL**

**P.O BOX 543, NYAHURURU. TELL 0703333111**

**XRAY/ LAB REQUEST FORM**

**DATE……………………………..**

**NAME……………………………………………………………………………………………….**

**AGE………….……….SEX……..…………………**

**DIAGNOSIS………………………………………………………….**

**INVESTIGATION(S) REQUIRED:**

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**DR’S………………………………………………SIGNATURE…………………………………………**

**Report**

**LAB TECH………………………………SIGN……………………………………………………………………**

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