



**Referral Form  
Radiology**

Date: \_\_\_\_\_

Referring Doctor: (Name), MD

Referring reason: Positive PPD results/ Past History of Positive PPD

\_\_\_\_\_ is authorized to have the following tests:

Chest X-Ray

Other

**Testing site Address:**

Radiology Vendor

Address

Phone

Fax

**Please send results to:**

Goddard Space Flight Center  
8800 Greenbelt Road, Mail Stop Cod 250.9  
Greenbelt, MD 20771  
Health Unit, Bldg. 97  
P-301-286-6666  
F-301-614-6942

Wallops Flight Facility  
32400 Fulton Ave  
Wallops Island, VA 23337  
Health Unit, F-160  
P-757-824-1266  
F-757-824-1497

**Please forward the invoice to:**

Medical Contractor

Attn: (Name)

Address

Phone

Fax

\_\_\_\_\_  
Signature of Health Care Provider