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Patient Information

Referring Doctor Information

Patient: _____

Referring Doctor: _____

D.O.B.: _____

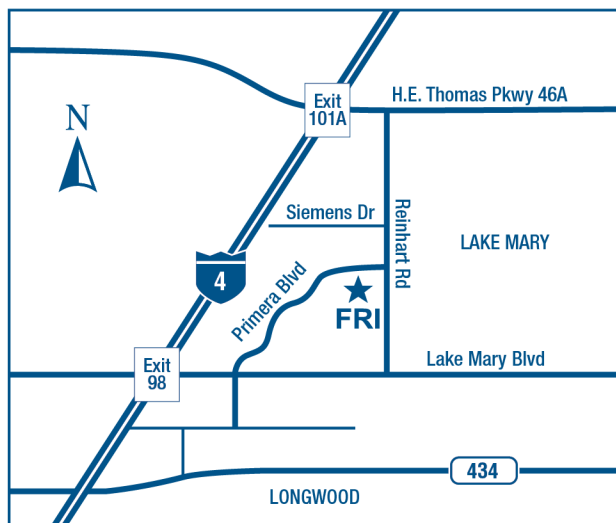
Referring Doctor Phone Number: _____

Patient Phone #: _____

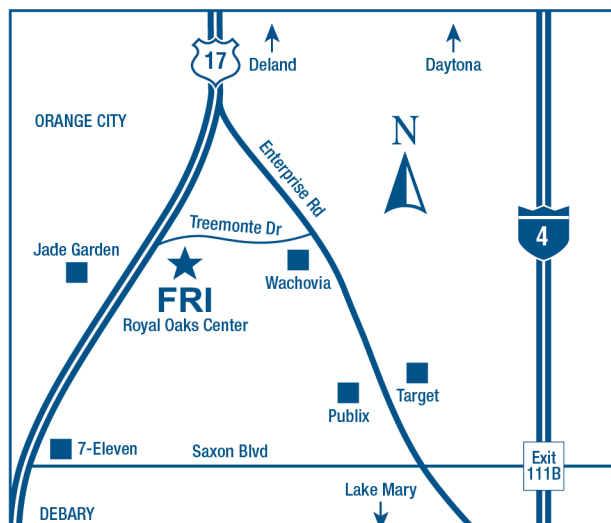
Referring Doctor Location: _____

Diagnosis/Reason for Referral:

Appointment: Date _____ Time _____



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