



*Vitreous - Retinal Diseases and Surgery*

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Patient: \_\_\_\_\_

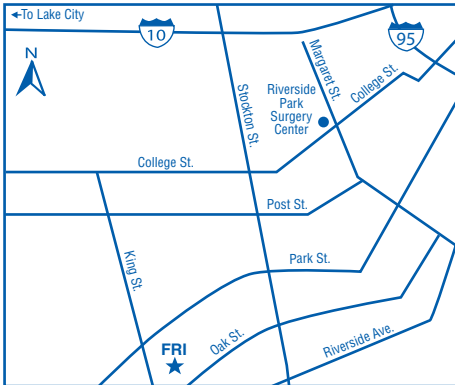
D.O.B.: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_

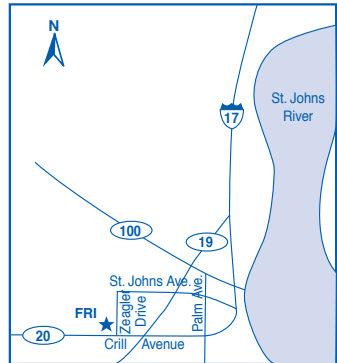
Referring Doctor: \_\_\_\_\_

Diagnosis/Reason for Referral:

Appointment: Date \_\_\_\_\_ Time \_\_\_\_\_



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