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Patient Information

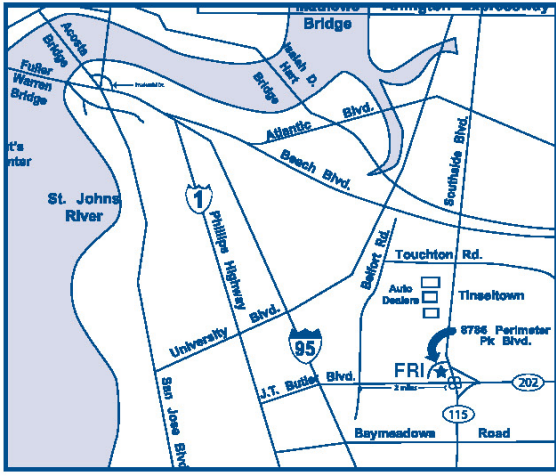
Referring Doctor Information

Patient: _____
 D.O.B.: _____
 Patient Phone #: _____

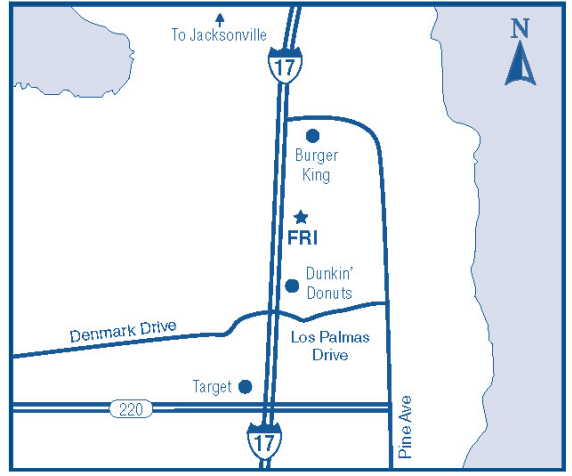
Referring Doctor: _____
 Referring Doctor Phone Number: _____
 Referring Doctor Location: _____

Diagnosis/Reason for Referral:

Appointment: Date _____ Time _____



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