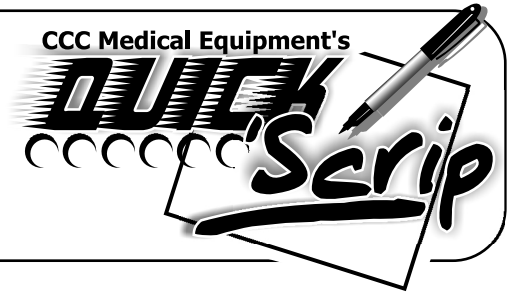


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Patient Name: _____

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Physician's Signature _____

Date of Order: _____