

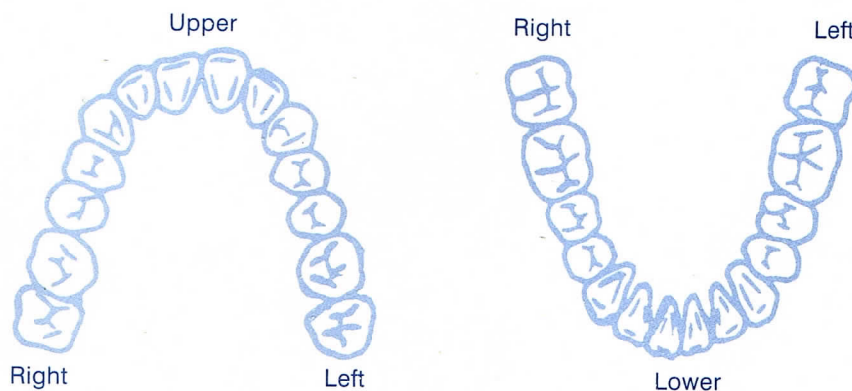
Dr. _____

Address: _____

_____ Date: _____

Patient: _____ Age: _____

Date Wanted: _____ Time: _____



INSTRUCTIONS

Signature: _____