

**Provider Information**

Provider/Physician Name \_\_\_\_\_

Referring Clinic \_\_\_\_\_

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

Email: \_\_\_\_\_

Address: \_\_\_\_\_

I would like to receive follow up:

Phone  Email  Not Needed

Send Full Medical Record

Patient's Signature \_\_\_\_\_

**Patient Information**

Patient's Name \_\_\_\_\_

Patient's DOB \_\_\_\_\_

Date of Service \_\_\_\_\_

Clinical Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

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**IMMEDIATE TREATMENT FOR:**

- Abdominal Pain
- Allergic Reaction
- Chest Pain
- Difficulty Breathing
- Fever/Flu
- Head or Neck Trauma
- Heart Attack
- Infections
- Lacerations
- Respiratory Distress
- Sports Injuries
- Stroke
- and more ...



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