TOTAL SPORTS MEDICINE & ORTHOPEDICS

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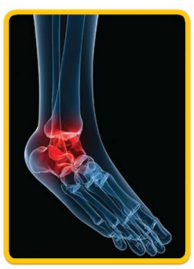
Date: _____

Patient Name: _____ Phone: _____

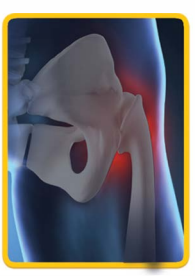
Problem:

☐ 
SHOULDER

☐ 
ELBOW

☐ 
ANKLE

☐ 
KNEE

☐ 
HIP

☐ OTHER: _____

Referring Physician: _____

Phone: _____ Fax or Email: _____

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