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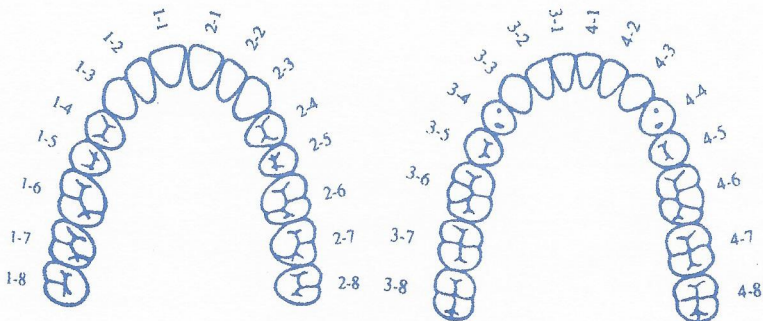
Clinic Name \_\_\_\_\_

Doctor \_\_\_\_\_

Address \_\_\_\_\_

Patient \_\_\_\_\_ M  F

<b>SHADE</b>	<b>MOULD</b>	
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**Rx**

DOCTOR'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_