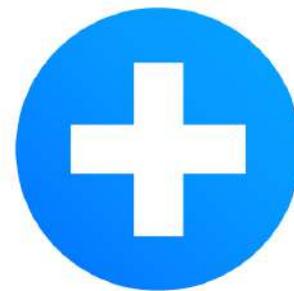


Dr. Doctor Name

QUALIFICATION



Patient Name: _____ Date: _____

Age: _____ Gender: _____ Weight: _____

Diagnosis: _____

Rx

Signature

 24 Dummy Street Area

 +12-345 678 9012