Advanced Integrated Medicine

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PATIENT NAME_____ **DOB**_____

REFERRING DOCTOR_____

PHONE_____ **FAX**_____

ULTRASOUND REQUESTED ☑ ALL THAT APPLY INDICATE RIGHT OR LEFT

	Shoulder		**Ankle**
	Knee		**Foot**
	Hip		**Finger**
	Elbow		**Nerve:**
	Wrist		**Other:**
	Arm		

Fees are collected per body part

CHIEF COMPLAINT_____

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COMMENTS_____