Physician Name: **Hospital:** **Page: __ of __**

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	**MONTH:** |_____|_____|			

Ref. Physician:

Ref Physician #: |____|____|____|____|____|____|

Admission Date: / / (DD/MM/YY)

Discharge Date: / / (DD/MM/YY)

Diagnosis Code: |_____|_____|_____|

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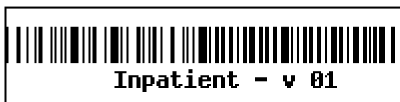

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