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Patient Name \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_

Patient telephone/email information \_\_\_\_\_

Significant pertinent history

Significant Test results

Diagnosis \_\_\_\_\_

Action Taken

- Patient/parent to call for appointment
- Referring doctor to call to make appointment
- Dr. Serex-Dougan to contact patient/parent

Patient/parent signature

Referring Doctor's name

Please FAX to 1-866-843-1385 or email to [dr.diane@verizon.net](mailto:dr.diane@verizon.net)