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Robin S. Collins, MPT, ATC

PATIENT'S NAME: _____ **DATE:** _____

DIAGNOSIS: _____

EVALUATE AND TREAT

PRECAUTIONS/ADDITIONAL INSTRUCTIONS: _____

Physician's Name (Print)

Physician's Signature

Physicians Medical Plaza
550 Redstone Avenue West, Suite 390
Crestview, Florida 32536
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Fax: 850-683-0099
(See map on back)



1950 Bluewater Boulevard, Suite 101
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