

HEALTH CHOICE CLINIC

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Dr. ABC DEF, FNP-C

Prescription no.:**[56]**

Date: **11/03/2025**

Mr./MS/Mrs.: **[Rangan]**

Age: **[5]**

Address: **[Patient Address Placeholder]**

Contact Num.: **[9609393003]**

A. Diagnosis/Symptoms:

No symptoms recorded.

B. Medications (R/):

No medications prescribed.

C. Consultation Notes:

No detailed transcription available.

Dr. Signature