

## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

Respiratory Symptoms: Cough [ ], Wheezing [ ], Crackle [ ], Ronchi [ ]

PFT Results(If Applicable): FVC: \_\_\_\_L, FEV1: \_\_\_\_L/sec, PEF: \_\_\_\_L/sec,

Physician Assessment (if any):

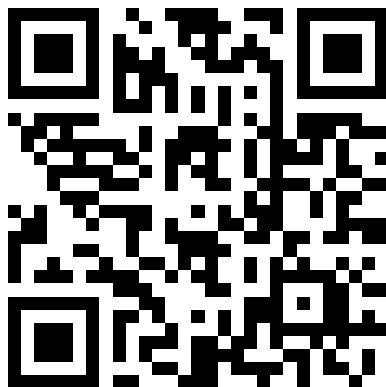
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Signature of Physician



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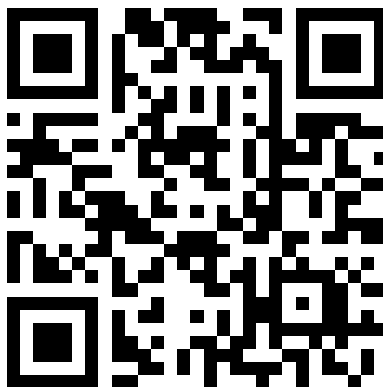
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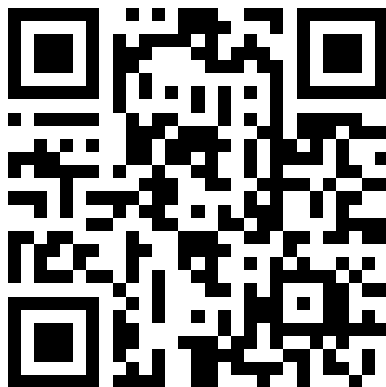
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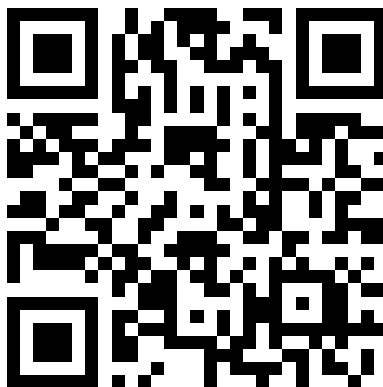
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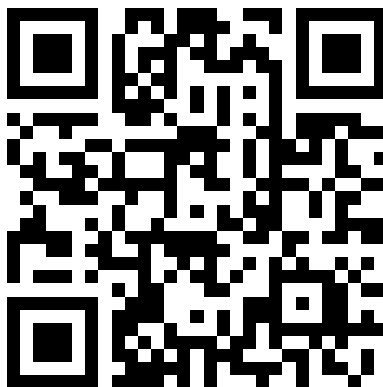
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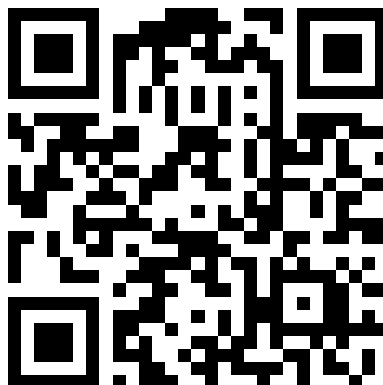
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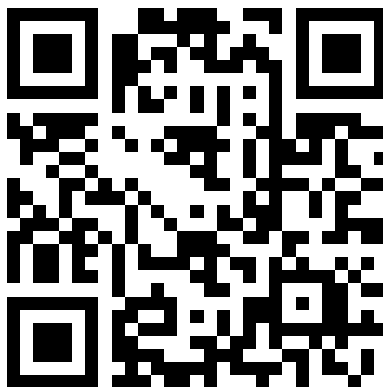
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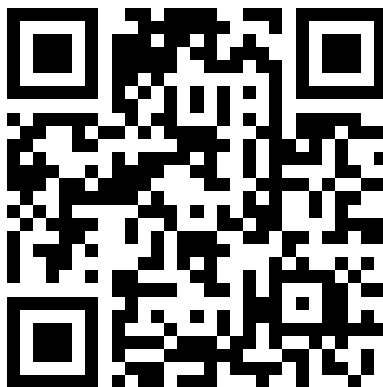
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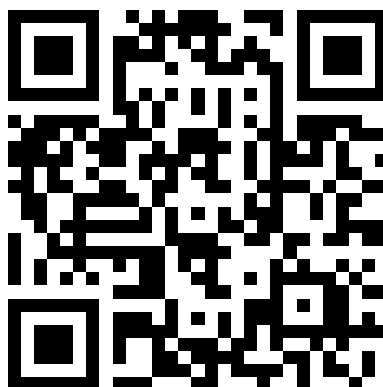
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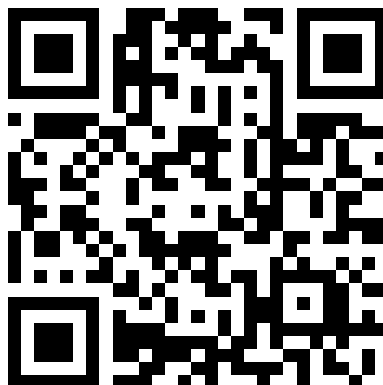
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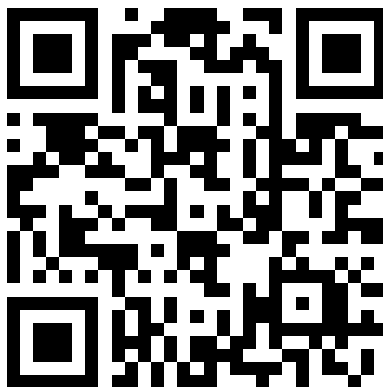
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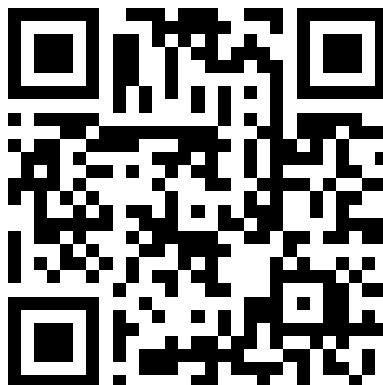
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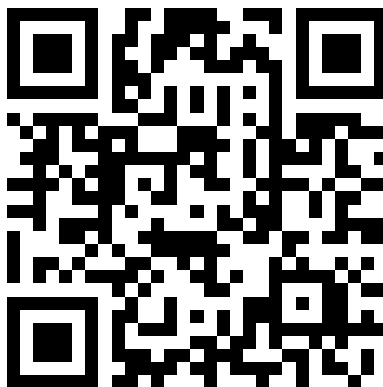
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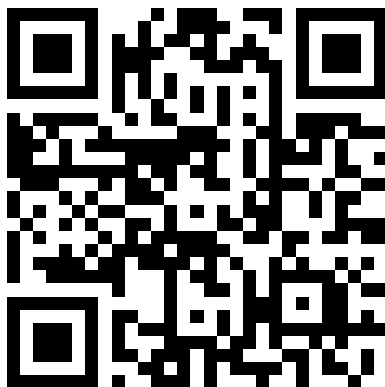
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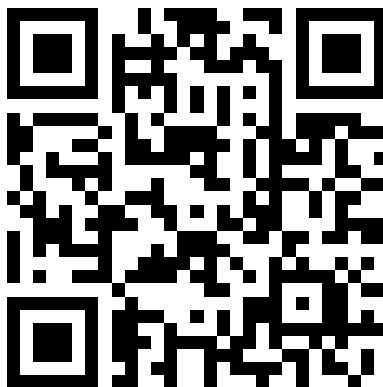
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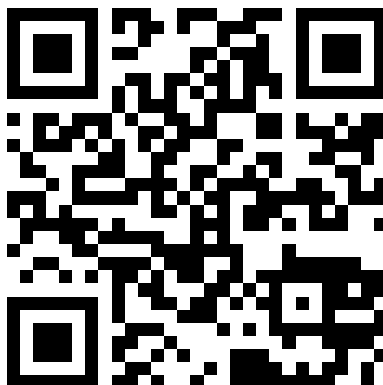
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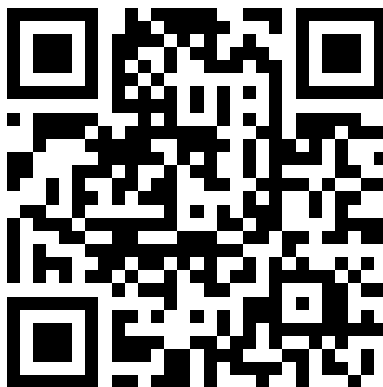
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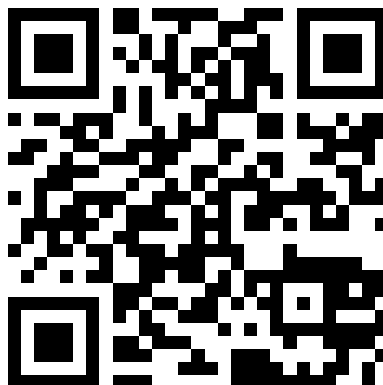
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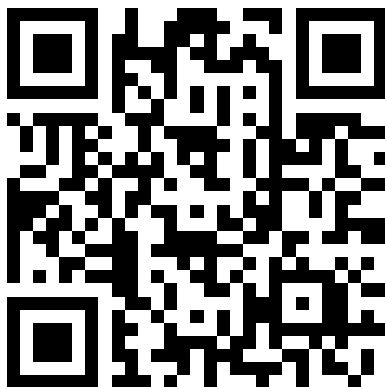
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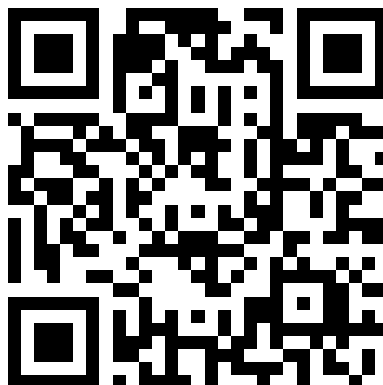
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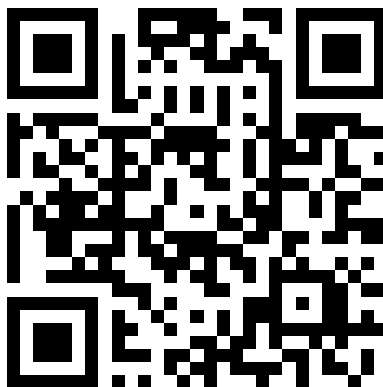
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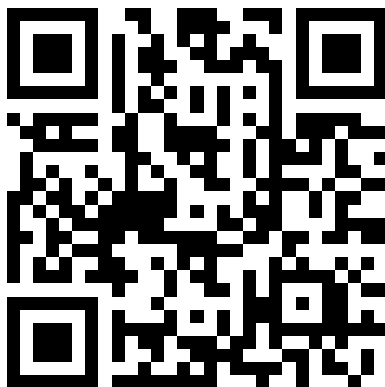
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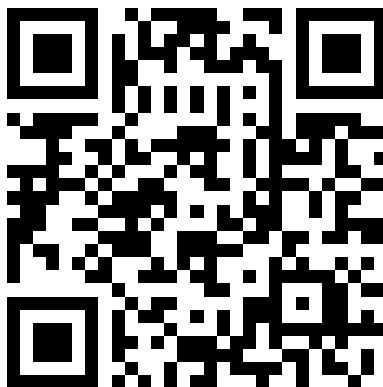
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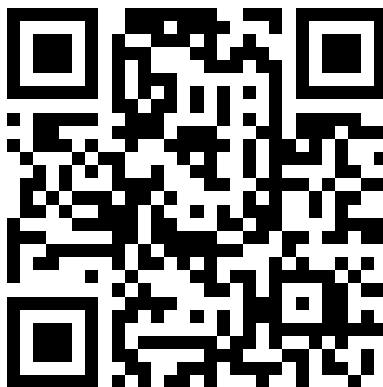
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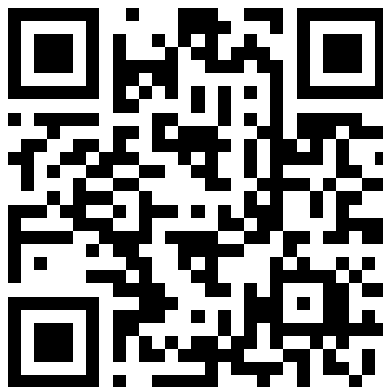
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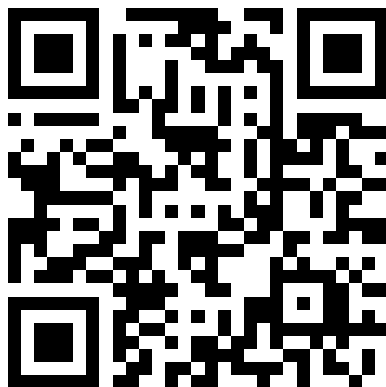
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

Respiratory Symptoms: Cough [ ], Wheezing [ ], Crackle [ ], Ronchi [ ]

PFT Results(If Applicable): FVC: \_\_\_\_L, FEV1: \_\_\_\_L/sec, PEF: \_\_\_\_L/sec,

Physician Assessment (if any):

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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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PFT Results(If Applicable): FVC: \_\_\_\_L, FEV1: \_\_\_\_L/sec, PEF: \_\_\_\_L/sec,

Physician Assessment (if any):

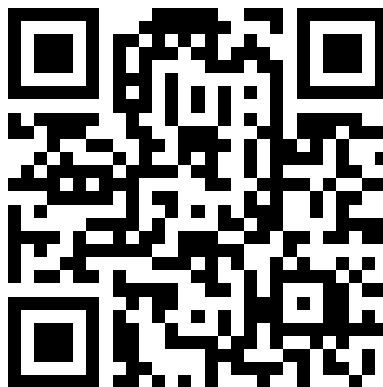
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

Respiratory Symptoms: Cough [ ], Wheezing [ ], Crackle [ ], Ronchi [ ]

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Physician Assessment (if any):

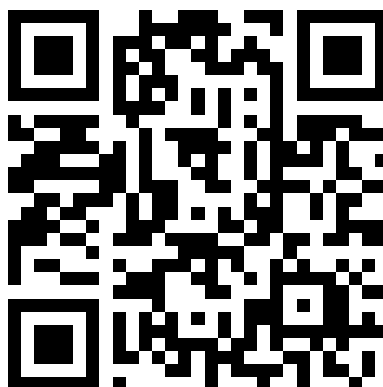
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

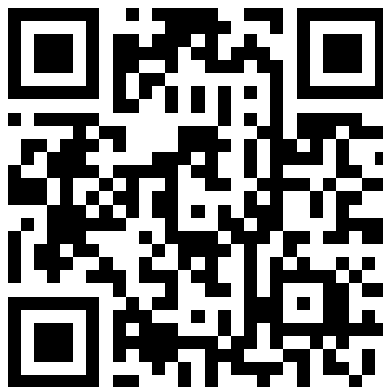
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Signature of Physician





## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

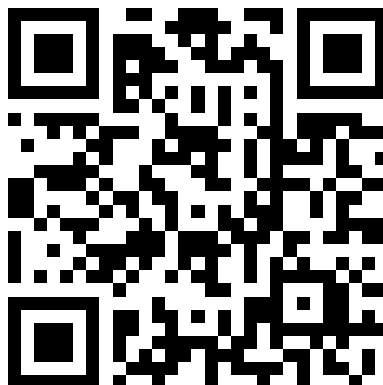
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Signature of Physician



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Signature of Physician



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Physician Assessment (if any):

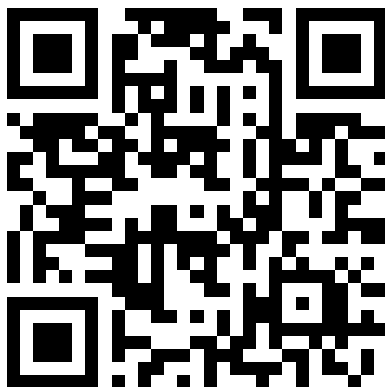
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

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Physician Assessment (if any):

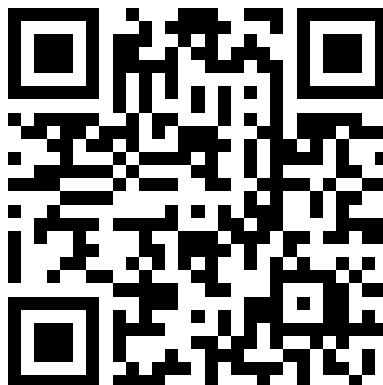
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Signature of Physician



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Physician Assessment (if any):

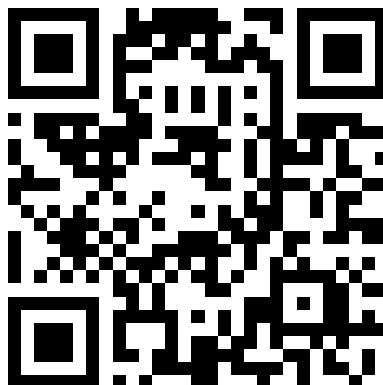
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

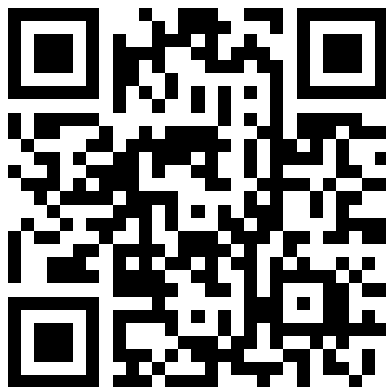
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Signature of Physician





## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

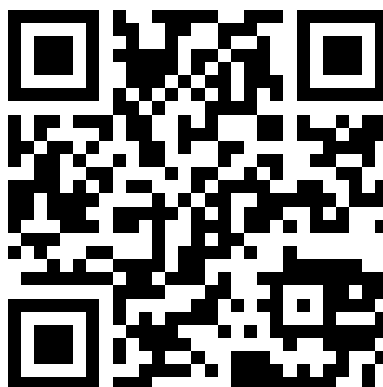
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Signature of Physician



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Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

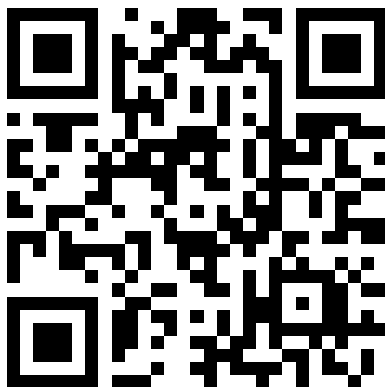
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

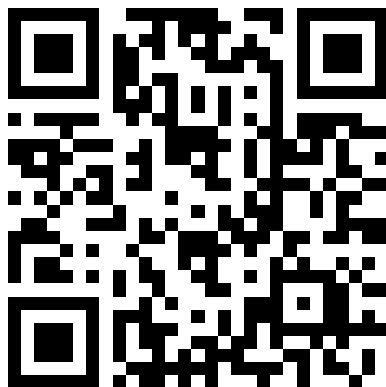
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

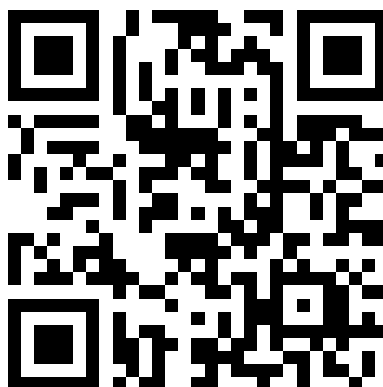
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Signature of Physician



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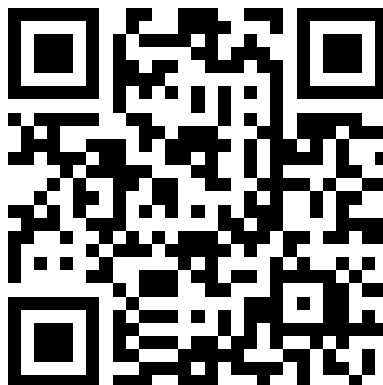
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

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Physician Assessment (if any):

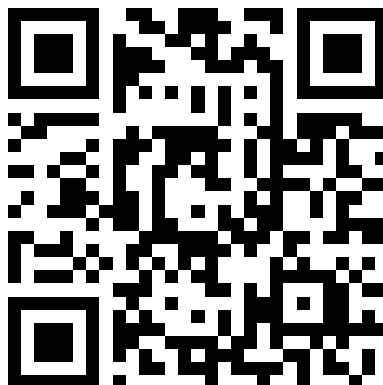
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

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Signature of Physician



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Physician Assessment (if any):

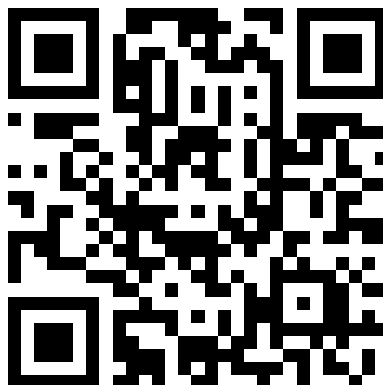
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Signature of Physician





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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

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Physician Assessment (if any):

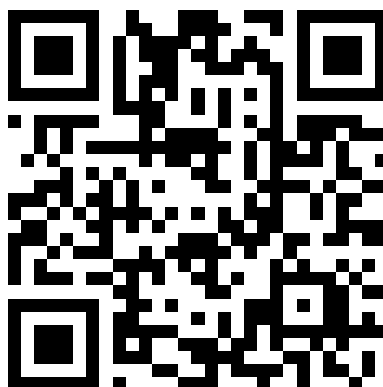
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

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Signature of Physician



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Signature of Physician



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Physician Assessment (if any):

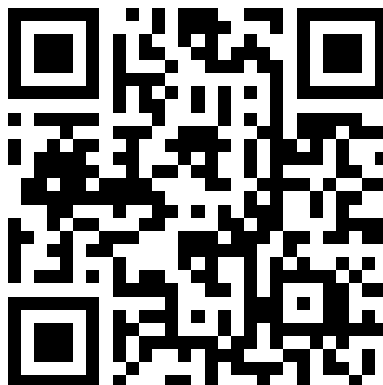
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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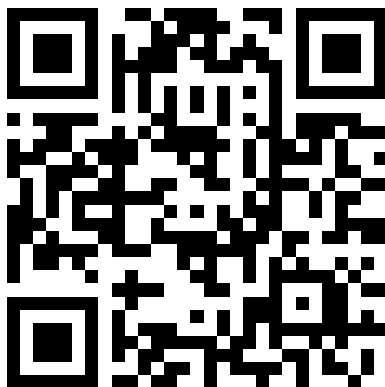
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

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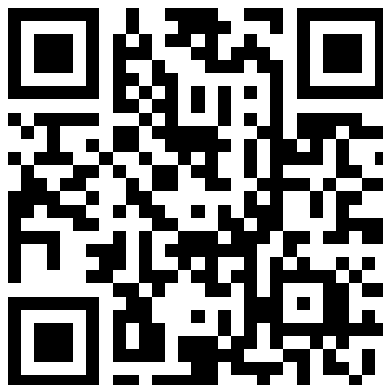
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

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Physician Assessment (if any):

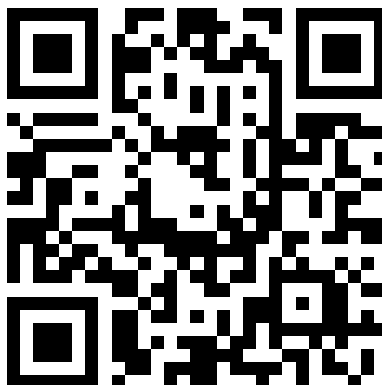
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Signature of Physician



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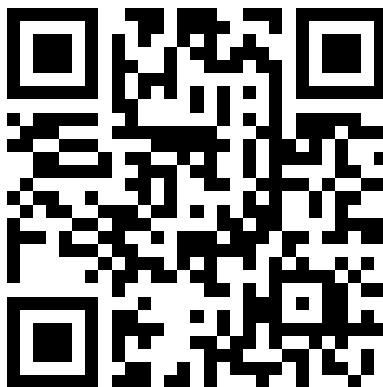
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Signature of Physician





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Physician Assessment (if any):

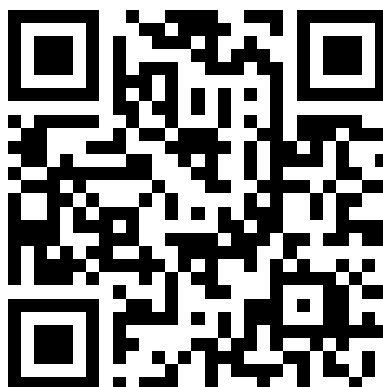
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Signature of Physician



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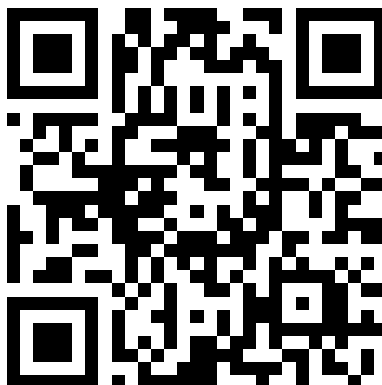
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Signature of Physician



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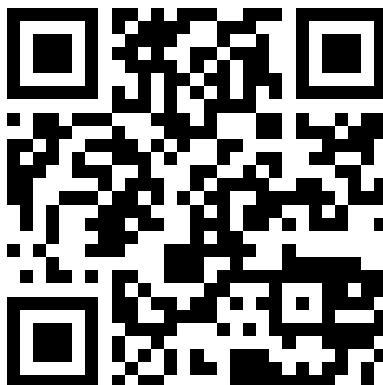
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Signature of Physician



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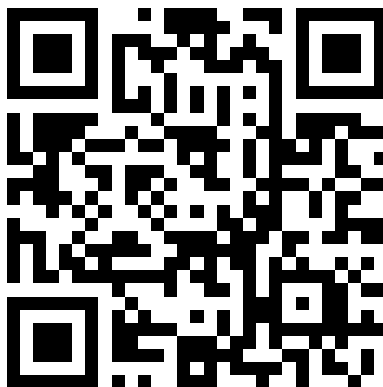
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Signature of Physician



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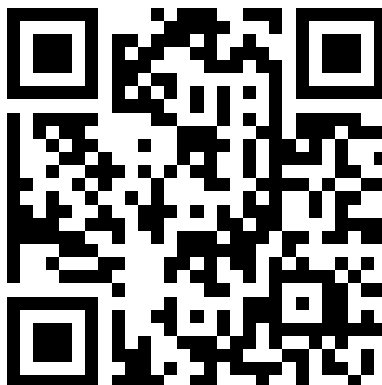
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Signature of Physician



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Physician Assessment (if any):

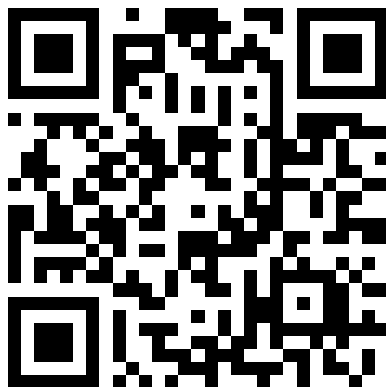
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

Respiratory Symptoms: Cough [ ], Wheezing [ ], Crackle [ ], Ronchi [ ]

PFT Results(If Applicable): FVC: \_\_\_\_L, FEV1: \_\_\_\_L/sec, PEF: \_\_\_\_L/sec,

Physician Assessment (if any):

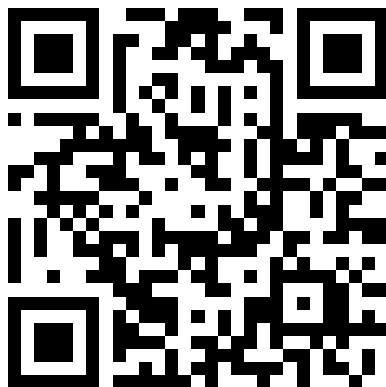
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

Respiratory Symptoms: Cough [ ], Wheezing [ ], Crackle [ ], Ronchi [ ]

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Physician Assessment (if any):

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Signature of Physician





## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

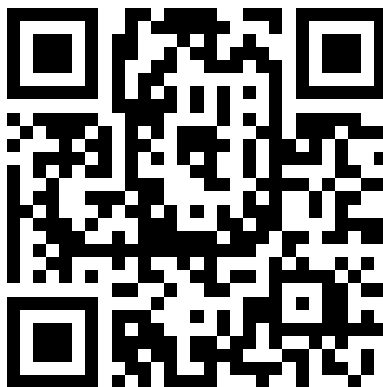
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

Respiratory Symptoms: Cough [ ], Wheezing [ ], Crackle [ ], Ronchi [ ]

PFT Results(If Applicable): FVC: \_\_\_\_L, FEV1: \_\_\_\_L/sec, PEF: \_\_\_\_L/sec,

Physician Assessment (if any):

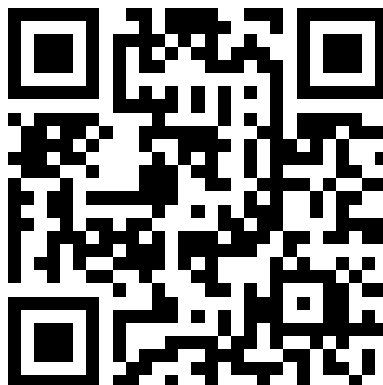
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

Respiratory Symptoms: Cough [ ], Wheezing [ ], Crackle [ ], Ronchi [ ]

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Physician Assessment (if any):

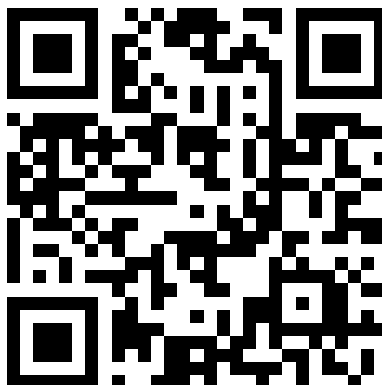
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

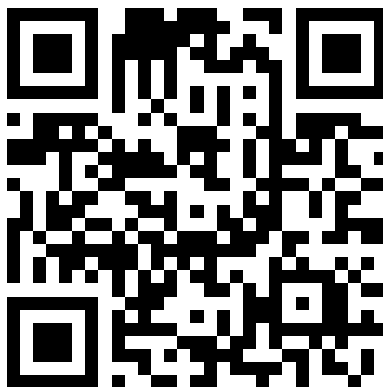
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

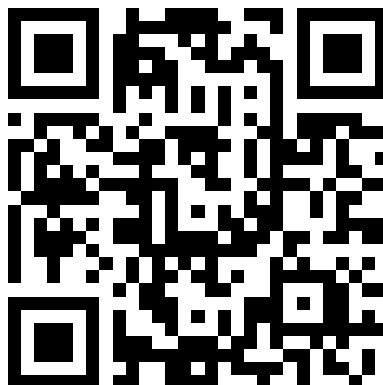
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

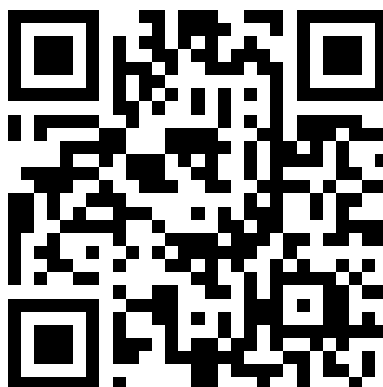
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

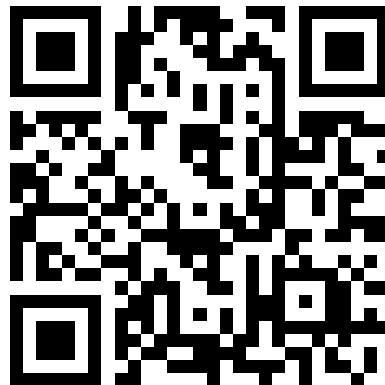
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Signature of Physician





## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

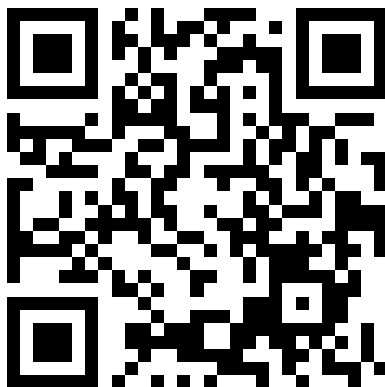
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

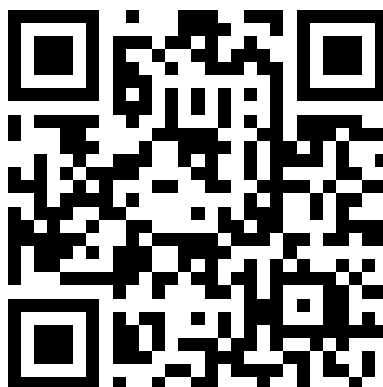
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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PFT Results(If Applicable): FVC: \_\_\_\_L, FEV1: \_\_\_\_L/sec, PEF: \_\_\_\_L/sec,

Physician Assessment (if any):

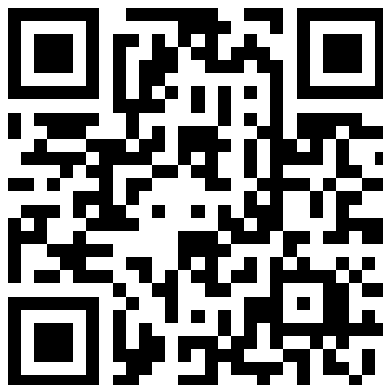
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

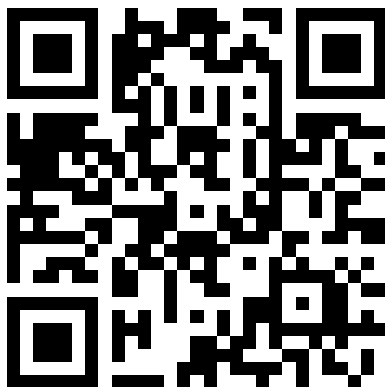
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

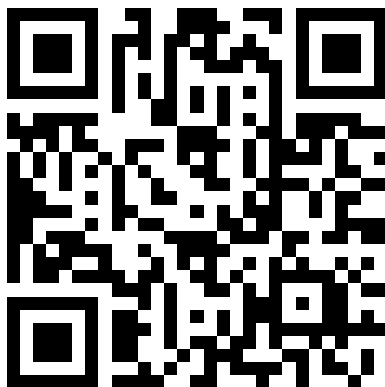
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

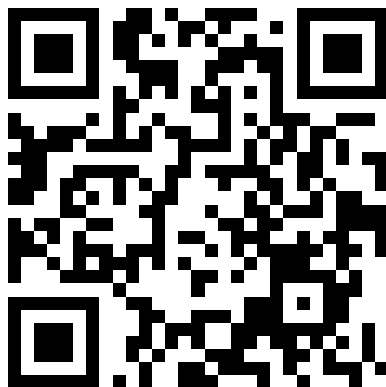
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

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Signature of Physician





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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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PFT Results(If Applicable): FVC: \_\_\_\_L, FEV1: \_\_\_\_L/sec, PEF: \_\_\_\_L/sec,

Physician Assessment (if any):

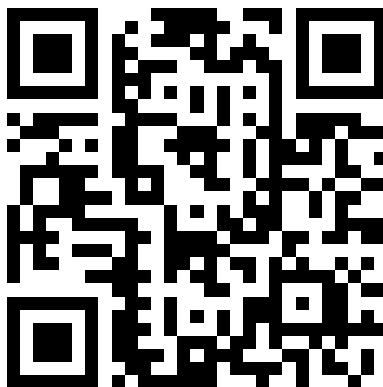
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

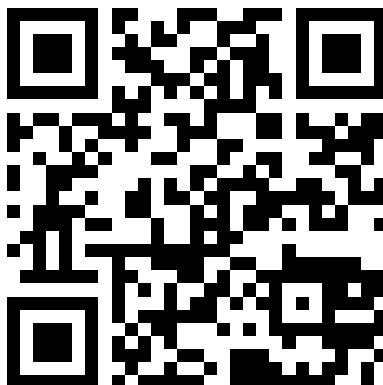
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

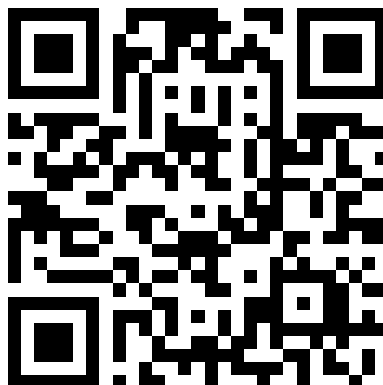
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

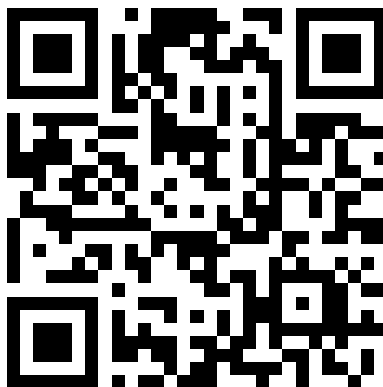
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

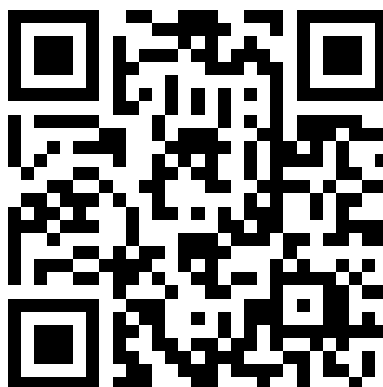
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

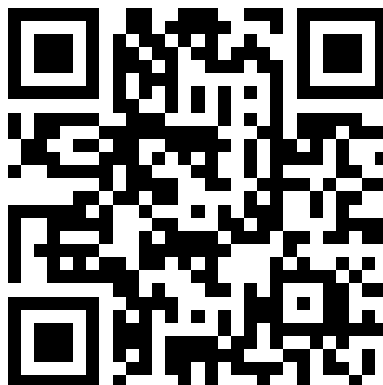
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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Physician Assessment (if any):

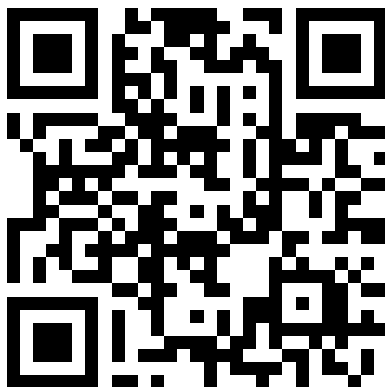
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Signature of Physician



## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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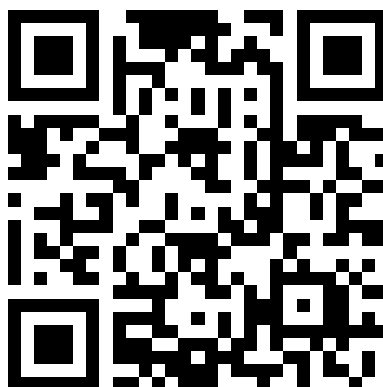
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Signature of Physician





## **Physician Assessment Form**

Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (HH:MM AM/PM): \_\_\_\_:\_\_\_\_

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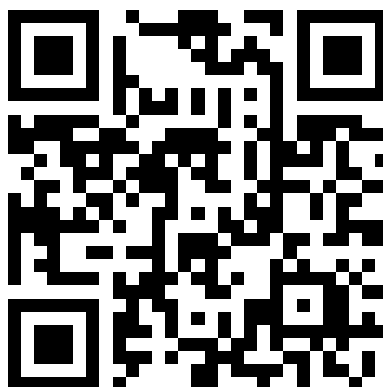
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

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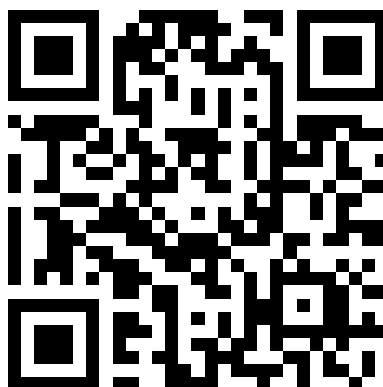
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Signature of Physician



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Patient Name: \_\_\_\_\_ YH Reg. Number: \_\_\_\_\_

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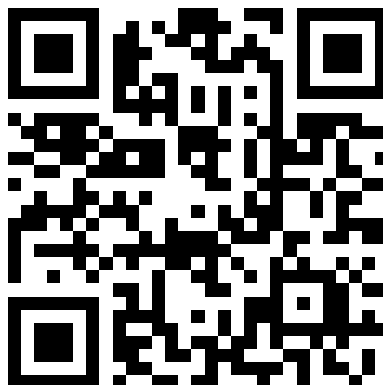
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Signature of Physician



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Signature of Physician

