

SERVIZIO SANITARIO NAZIONALE
REGIONE PIEMONTE
Azienda Sanitaria Locale
"Città di Torino"

AMBULATORIO
di LASER TERAPIA

Data.....

CognomeNome.....nato/a

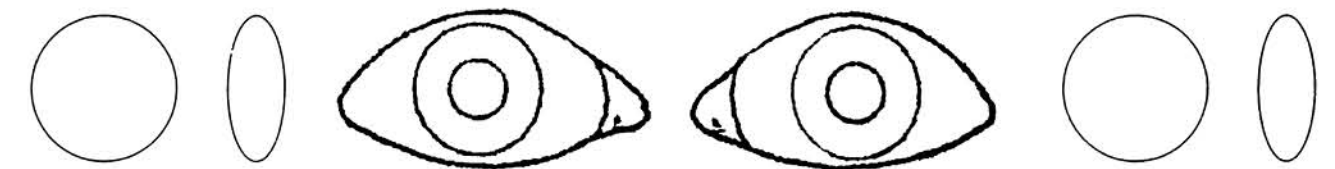
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DIAGNOSI OD.....

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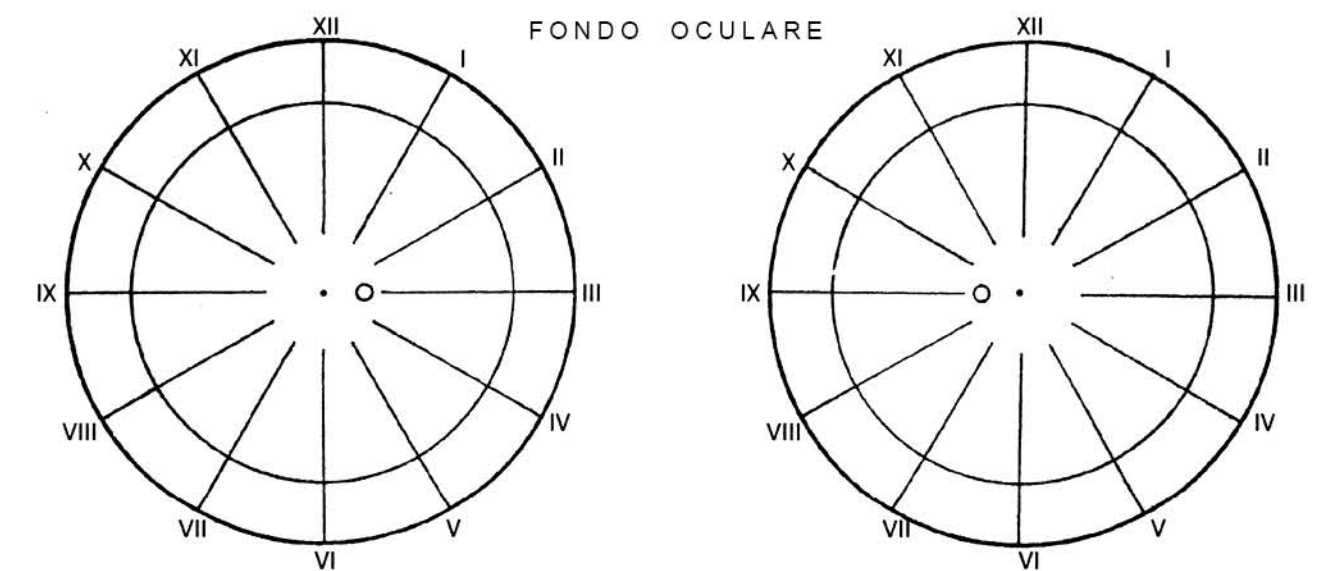


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