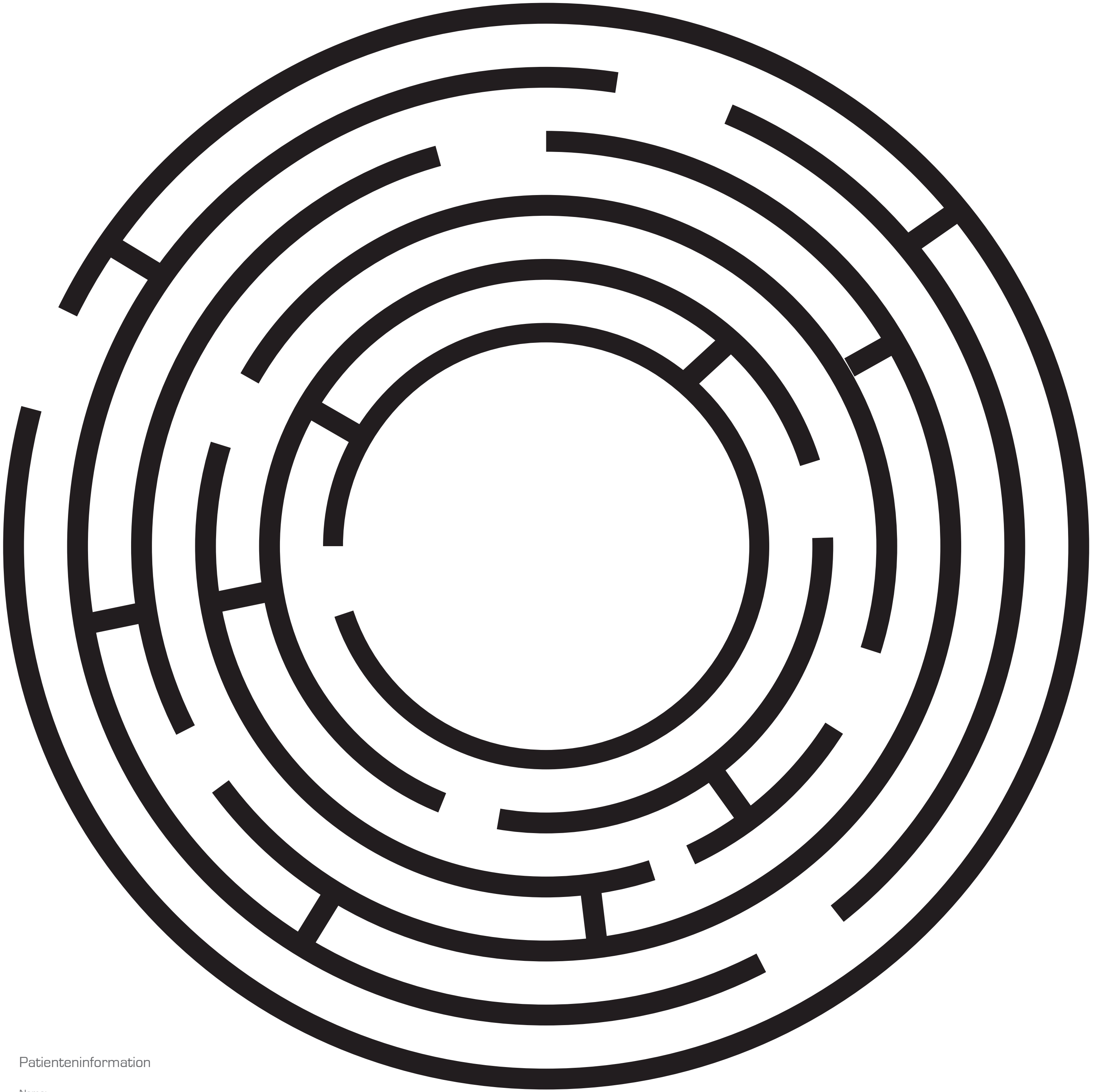




Patienteninformation

Name: _____
Vorname: _____
Datum: _____

Therapeut: _____



Patienteninformation

Name: _____
Vorname: _____
Datum: _____

Therapeut: _____

