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| **NOMBRE DEL PACIENTE:** | | | | | **FECHA** | |
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| **DIAGNOSTICO** | | | | | | |
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|
| **ESPECIALIDAD** | |  |  |  |  |  |
| GINECOLOGIA\_Y\_OBSTETRICIA | | | | | | |
| **NOMBRE DE LA CIRUGIA** | | | | | | |
| CISTOLITOTRIPSIA (CISTOSCOPIO EQUIPO LASER) PARTICULAR PRIV. | | | | | | |
|  | | | | | | |
| **CIRUGIA URGENTE/ORDINARIO** |  | **EQUIPO MEDICO QUE PARTICIPARA** | | | | |
| ORDINARIO | | |  | | --- | |  | |  |  |  |  |
| **TIPO DE ANESTESIA** | |  | | | **ESTANCIA SUGERIDA EN DÍAS** | |
| LOCAL | | 3 | |
| **EQUIPO ELECTROMÉDICO ADICIONAL SOLICITADO** | | | | | | |
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| **OBSERVACIONES** | | | | | | |
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[Nombre y cedula]

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[Nombre solicitante]