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| coopsolidale | Residenza Protetta Anziani (R3-R3D)  “**MADONNA DELLA VITA**” | Cod. ROG26-33  Rev.02 del 30.06.2025 |

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|  | CARTELLA INFERMIERISTICA - ASSISTENZIALE |  |  | R3 |  |  | R3D |  |
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| **CODIFICA UTENTE:** |  | COGN. |  | NOM. | **Cod. DOSSIER UTENTE N°** |  |  |  | **R3** |  | **R3D** |

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| **DATA RICOVERO:** |  |  |  |  | **DATA DIMISSIONE:** |  |  |  |

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| Cognome |  | | | | | | | | | | Nome | | | | | |  | | | | | | | | | | Genere | | | **M** | |  | | | **F** | |  |  |
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| Data di nascita | |  | | | | | Luogo di nascita | | | | | | | |  | | | | | | | | | | | | | | | | | Prov. | | | |  | | |
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| Residente in | | |  | | | | | | | | | | | Prov. | | | | |  | | Via | |  | | | | | | | | | | | N° | |  | | |
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| **Codice Fiscale** | | |  | |  |  | |  |  |  | |  | | | |  | |  | |  | |  | |  | |  | |  |  | |  | |  | | | | | |
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| **Grado di istruzione** | | | |  | | | | | | | | | **Attività lavorativa svolta** | | | | | | | | | | | |  | | | | | | | | | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Referente/ADS** |  | Tel. |  | Mail |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Familiare** |  | Tel. |  | Mail |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Familiare** |  | Tel. |  | Mail |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **M. M.G.** | Recapiti telefonici | E-mail |
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| **CODICE TESSERA SANITARIA:** |  |

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| PATOLOLOGIE: | ❒Cardiopatia | ❒Ipertensione | ❒Diabete | ❒Celiachia | ❒TAO | ❒Asma | ❒ |  |

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| PROBLEMATICHE TERAPEUTICHE: | ❒ Nessuna | ❒ Ossigeno terapia | ❒ TAO | ❒Dialisi | ❒ | ❒ |

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| PRESIDI: | ❒ | SNG | ❒ | PEG | ❒ | NPT | ❒ | Catetere | ❒ | Stomia | ❒ | Drenaggio | ❒ CPAP | ❒Pace maker | ❒ |

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| PROTESI: | ❒ Dentaria | ❒ Oculare | ❒ Uditiva | ❒ Ortopedica | ❒Vascolare | ❒ | ❒ |

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| POSITIVITA’ SIEROLOGICA: | Epatite: | ❒ | A | ❒ | B | ❒ | C | ❒ | D | ❒ | E | ❒ | HIV | ❒ | ❒ |

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| INTOLLERANZE ALIMENTARI: |  |  |  |

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| ALLERGIE: |  |  |  |  |

**CONVENZIONATO AST** ❏**SI** ❏**NO** **VALUTAZIONE UVI** ❏**SI** ❏**NO** **VALUTAZIONE CDCD** ❏**SI** ❏**NO**

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| **Servizio Inviante** | **Referente** | **Recapiti Telefonici/ E-mail** |
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| NOTE: |  |
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| **Infermiere** compilatore |  | **FIRMA** |  |