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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| No. H. C. |  | | | | FECHA | |  | | | ADMISION | | |  | | | CONSECUTIVO |  |
| FECHA INGRESO |  | | | FECHA SALIDA | | | |  | | | | TIPO ATENCION | |  | | | |
| GRUPO SERVICIOS | |  | | | | | | | | MODALIDAD DEL SERVICIO | | | | | |  | |
| ORIGEN INCAPACIDAD | | |  | | | PRORROGA | | |  | | INC. RETROACTIVA | | | |  | | |

IDENTIFICACIÓN DEL PACIENTE

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| PACIENTE |  | DOC. ID. |  | | |
| LUGAR NAC. |  | FEC. NAC. |  | | |
| E. CIVIL |  | EDAD |  | | |
| OCUPACIÓN |  | SEXO |  | | |
| CIUDAD |  | BARRIO |  | | |
| DOMICILIO |  | TELÉFONO |  | | |
| REGIMEN |  | CAUSA EXTERNA |  | | |
| EPS |  | DX PRINCIPAL |  | DX REL |  |
| FECHA INICIO |  | FECHA FIN |  | | |

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|  |
| Se expide la presente incapacidad por (3) día(s), debido a que el paciente presenta la siguiente patología: |
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|  |
| Para constancia se firma el día |

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| Dr(a). | | |
| REGISTRO NO. |  | Esp. M |
| DOCUMENTO |  | |