Hospital Regional do Gama - DF

SETOR: CLÍNICA ORTOPÉDICA **LEITO:**

NOME:_____

PROCEDIMENTO REALIZADO:

DATA DE NASC.:

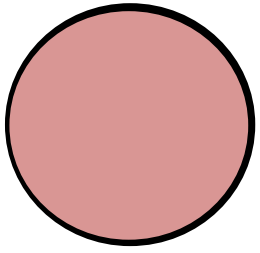
_____/_____/_____

DATA DE ADMISSÃO:

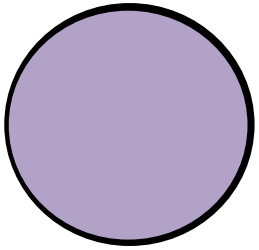
_____/_____/_____

SES:

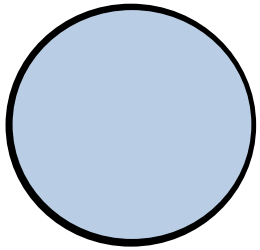
_____



RISCO DE QUEDA



RISCO DE LPP



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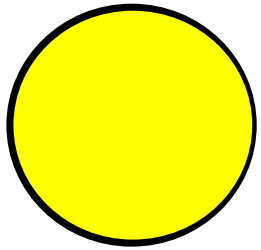
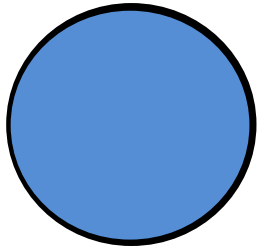


ALERGIA



ISOLAMENTO