

Hospital Regional do Gama - DF

SETOR: CLÍNICA CIRÚRGICA

LEITO:

NOME: _____

PROCEDIMENTO REALIZADO:

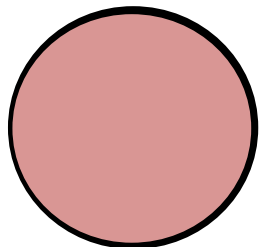
DATA DE NASC.:

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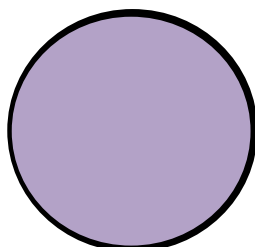
DATA DE ADMISSÃO:

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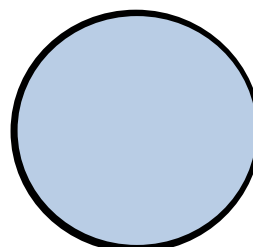
SES:



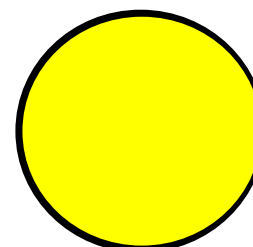
RISCO DE QUEDA



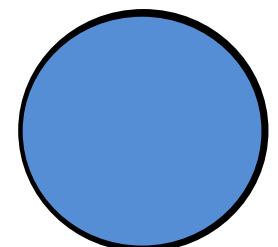
RISCO DE LPP



RISCO DE TEV



ALERGIA



ISOLAMENTO