Hospital Regional do Gama - DF

SETOR: Maternidade LEITO:

NOME:_____

Nº SES:_____ **Nº PULSEIRA:**_____

RN – SEXO : F ( ) M ( ) / F ( ) M ( )

Nº PULSEIRA:_____ **/ Nº PULSEIRA:**_____

DATA DE NASC. (Mãe):

_____/_____/_____

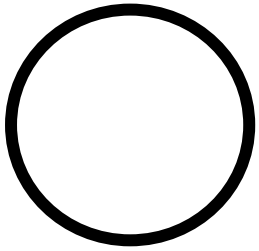
DATA DE NASC. (RN):

_____/_____/_____

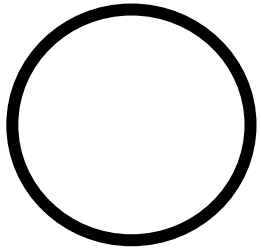
HORA: _____

DATA DE ADMISSÃO:

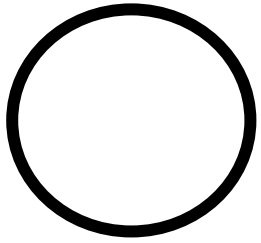
_____/_____/_____



RISCO DE QUEDA



RISCO DE LPP



ALERGIA

TIPO DE PARTO:

( ) **NORMAL**

( ) **CESARIANA**

( ) **Fórceps**