

Hospital Regional do Gama - DF

SETOR: CENTRO OBSTÉTRICO

PASSAGEM: _____

NOME: _____

Nº SES: _____

TIPO DE PARTO: () **NORMAL** () **CESARIANA** () **Fórceps**

ANESTESIA: _____

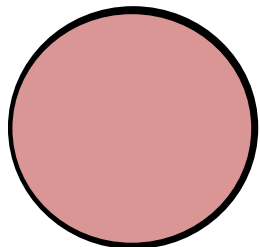
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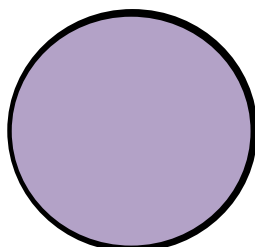
DATA DE ADMISSÃO:

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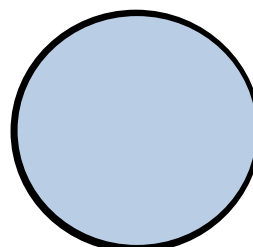
PROCEDÊNCIA:



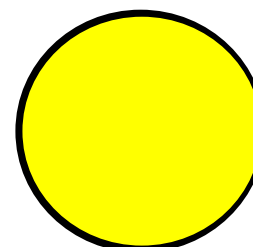
RISCO DE QUEDA



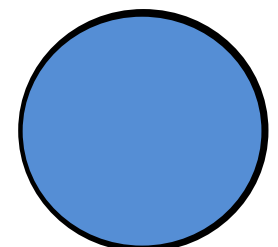
RISCO DE LPP



RISCO DE TEV



ALERGIA



ISOLAMENTO