

**SETOR:** CLÍNICA ORTOPÉDICA

**LEITO:**

**NOME:** \_\_\_\_\_

**PROCEDIMENTO REALIZADO:**

**DATA DE NASC.:**

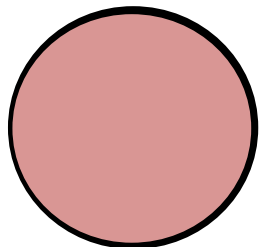
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**DATA DE ADMISSÃO:**

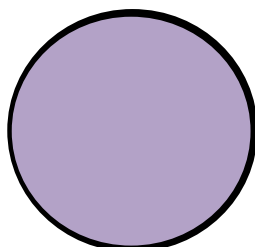
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**SES:**

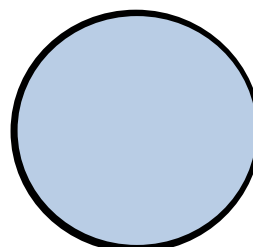
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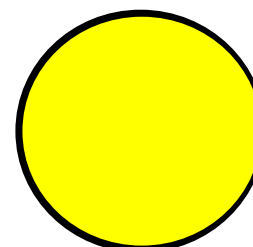
**RISCO DE QUEDA**



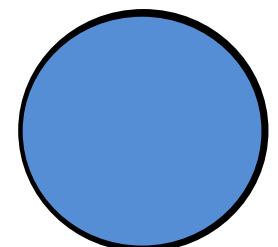
**RISCO DE LPP**



**RISCO DE TEV**



**ALERGIA**



**ISOLAMENTO**