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| Dados da loja  CNPJ: 00.000.000/0000-00  Endereço:  Fone:  **DECLARAÇÃO DE SERVIÇOS FARMACÊUTICOS**  **CUIDADOS FARMACÊUTICOS**  Gênero: ( ) Masculino ( ) Feminino  Idade:    anos  Endereço:  Nome do responsável (em caso de menor):  Médico(s) do paciente (se aplicável):  Telefone(s):  E-mail:  Nome:   |  |  |  |  | | --- | --- | --- | --- | | Sim ( ) | Não ( ) | **Glicemia Capilar:** | Valor normal: 70 a 99mg/dl | |  |  |  |  | | Sim ( ) | Não ( ) | **Pressão Arterial:** | Valor normal: < 120x < 80mm/Hg | | Sim ( ) | Não ( ) | **Temperatura Corporal Axilar:** | Valor normal: 36 a 37 Co |   Obs.: Estes procedimentos não tem finalidade de diagnosticar e não susbtituem a consulta médica ou a realização de exames laboratoriais.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Sim ( ) | | | Não ( ) | Aplicação de injetáveis | | | | | | | |  | | |  | | | | | Medicamento/concentração | | | | | | Lote | | | Validade | | | Posologia | | | Via de administração | | | | |  | | | | | |  | | |  | | |  | | |  | | | | | Nome do prescritor: | | | | | | | | | | | |  | | | CRM/CRO: | | | | | Medicamento/concentração | | | | | | | | Lote | | | Validade | | | | | Posologia | | | |  | | | | | | | |  | | |  | | | | |  | | | |  | | | | | | | |  | | |  | | | | |  | | | |  | | | | | | | |  | | |  | | | | |  | | | | Nome do prescritor: | | | | | | | |  | | |  | | | | | CRM: | | | | Sim ( ) | | Não ( ) | | **Colocação de Brincos:** | | | | | | | |  | | | | |  | | | Pistola (Fabricante) | | | |  | Lote | |  | | | | | CNPJ | | | | |  | | |  | | | |  |  | |  | | | | |  | | | | |  | | | Brinco (Fabricante) | | | |  |  | | CNPJ | | | | | Lado direito | | | | | Lado esquerdo | | |  | | | |  |  | |  | | | | | S ( ) N ( ) | | | | | S ( ) N ( ) | | |  | | | |  | | | | | | | | | | | | |  | | | Sim ( ) | Não ( ) | | | **Assistência Farmacêutica Domiciliar** | | | | | | | | | |  | | | | | |  |  | | |  | | | | | | | | | |  | | | | | | Sim ( ) | Não ( ) | | | **Acompanhamento Farmacoterapêutico** | | | | | | | | | | N ficha:o | | | | | | Sim ( ) | Não ( ) | | | **Indicação Farmacêutica em Transtornos Menores** | | | | | | | | | | | | | |  | | Sinais e sintomas: | | | | | | | | | | | | | | | | | |  | | Medicamento/concentração | | | | | | | | | | Lote | | | Validade | | | | | Posologia | |  | | | | | | | | | |  | | |  | | | | |  | |  | | | | | | | | | |  | | |  | | | | |  | |  | | | | | | | | | |  | | |  | | | | |  | |  | | | | | | | | | |  | | |  | | | | |  | | Plano de acompanhamento (intervalo) | | | | | | | | | | ( ) 2 dias | | | ( ) 4 dias | | | | | ( ) 6 dias |   Data: \_ / /\_\_\_\_\_\_\_\_  Assinatura do Usuário/responsável Assinatura do Farmacêutico CRF/UF |