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| INFORMACIÓN GENERAL | | | | | | | | | | | | | | | |
| FECHA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ HORA INGRESO: \_\_\_\_\_\_\_\_\_\_ HORA SALIDA: \_\_\_\_\_\_\_\_\_\_ CONSECUTIVO: \_\_\_\_\_\_\_\_\_  NOMBRE DEL PACIENTE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENERO: F\_\_\_ M\_\_\_  TIPO DE ID: CC\_\_\_ TI\_\_\_ CE\_\_\_ OTRO\_\_\_\_ CODIGO\_\_\_\_\_\_\_\_\_\_\_\_\_ No IDENTIFICACIÓN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  EDAD: \_\_\_\_\_ EPS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ARL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELULAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| ESTUDIANTE: \_\_\_\_ DOCENTE: \_\_\_\_ ADMINISTRATIVO: \_\_\_\_ SEGURIDAD: \_\_\_\_ S. GENERALES: \_\_\_\_ OTROS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| DATOS DEL RESPONSABLE Y/O ACOMPAÑANTE | | | | | | | | | | | | | | | |
| NOMBRE DEL RESPONSABLE O ACOMPAÑANTE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PARENTESCO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELULAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| MOTIVO DE CONSULTA, SITUACIÓN PRESENTADA (Qué paso, cómo, dónde, lugar anatómico, tiempo evolución y síntomas) | | | | | | | | | | | | | | | |
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| VALORACIÓN PRIMARIA (ABC) | | | | | | | | | | | | | | | |
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| VALORACIÓN SECUNDARIA (Hallazgos del Examen Cefalocaudal) | | | | | | | | | | | | | | | |
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| ANTECEDENTES | | | | | | | | | | | | | | | |
| Farmacológicos: | | | | | | | | | | Gineco obstétricos: G\_\_\_ P\_\_\_ C\_\_\_ A\_\_\_ V\_\_\_ | | | | | |
| Quirúrgicos: | | | | | | | | | | Familiares: | | | | | |
| Tóxicos Alérgicos: | | | | | | | | | | Patológicos: | | | | | |
| SIGNOS VITALES | | | | | | | | | | | | | | | |
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| ACCIONES REALIZADAS | | | | | | | | | | | | | | | |
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| RECOMENDACIONES (Educación en salud e indicaciones de autocuidado dadas al paciente) | | | | | | | | | | | | | | | |
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| OBSERVACIONES | | | | | | | | | | | | | | | |
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| ÁREA PROTEGIDA | | | | | | | | | | | | | | | |
| Hora de activación del servicio: \_\_\_\_\_\_\_\_ | | | | Funcionario quien atiende: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Hora de llegada de Ambulancia: \_\_\_\_\_\_\_\_\_ | | | | | Hora de Salida de Ambulancia: \_\_\_\_\_\_\_\_\_ | |
| No. De Móvil:  \_\_\_\_\_\_\_\_\_ | Ambulatorio:  Si: \_\_\_\_ No: \_\_\_\_\_ | | | | TAM: \_\_\_ | | | TAB: \_\_\_ | | | Remitido:  Si: \_\_\_ No: \_\_\_ Donde: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Observaciones: | | | | | | | | | | | | | | | |
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| NOMBRE: | | CEDULA: | | | | CARGO: | | | | | FIRMA responsable con registro | | | | |
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| FINALIZACION DE ATENCIÓN DE PRIMEROS AUXILIOS | | | | | | | | | | | | | | | |
| Firma del paciente, responsable o acompañante: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Documento de identidad: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| Firma de testigo: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Documento de identificación: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| Con mi firma certifico que realicé todas las actividades descritas en el presente documento al paciente en mención.  Firma de Auxiliar de Enfermería: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Documento de identidad: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |