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| **Data da solicitação, \_\_\_/\_\_\_\_\_/ 20\_\_\_.**  **Provável data da realização do procedimento:\_\_\_/\_\_\_/ 20\_\_\_\_.**  **Beneficiário:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Idade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sexo:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Médico solicitante: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Local da execução (Hospital, Clínica): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Tipo de Atendimento:** Ambulatorial ( ) Internamento ( ) Nº de Diárias:\_\_\_\_\_\_\_\_ |

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| **Caráter da Internação**: E – Eletivo ( ) U – Urgência / Emergência ( ) |
| **Procedimentos solicitados códigos:**  **Histórico Clínico / Sintomas/ especificar hipótese diagnóstica para indicação do procedimento:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Exames realizados:**  **( )** Arteriografia **( )** Angio TC **( )** Eco Dopller **( )** Angio RM  **( )** Outros - especificar:  **Artéria(s) Alvo de tratamento:**  **( )** MIE **( )** MID **( )** MSE **( )** MSD **( )** outra, qual:  **Tratamentos já utilizados**:    **( )** Fármacos; especificar:  **( )** Angioplastia/Stent:  **( )** Cirurgias – especificar:  **Co-morbidades:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Solicitada cirurgia de:**  **( )** By-pass FEPO proximal  **( )** By-pass FEPO distal  **( )** By-pass FEMORO-FEMORAL CRUZADO  **( )** By-pass Aorto-bi-femoral  **( )** By-pass Aorto-femoral  **( )** Endarterectomia carotídea  **( )** Outra, qual **: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Justificativa Médica:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  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Por gentileza, enviar estes esclarecimentos juntamente com o Pedido Médico e preferencialmente de maneira digitada devido ao borramento no Fax e/ou Scanner.

**Fornecer o número do telefone celular e e-mail para contato**:

Celular: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A Unimed Grande Florianópolis aguardará este documento conforme descrito acima para proceder com a autorização.

**Materiais Necessários:**

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| **CÓDIGO** | **DESCRIÇÃO** | **QUANT.** | **FORNECEDOR** |
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**IMPORTANTE ANEXAR ESTA FICHA AO PEDIDO MÉDICO**