|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Identificación del Paciente** | | | | | | |
| DNI: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Apellidos y nombres: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Fecha de nacimiento: | | \_\_\_/\_\_\_\_/\_\_\_\_\_ | | Sexo: | Fem. Masc. | |
| Domicilio actual: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Obra social: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Antecedentes del Paciente** | | | | | | |
| **Determinación urgente**  SI  NO  **Internación** SI  NO  **Fecha de trasplante** \_\_\_/\_\_\_/\_\_\_\_\_  **Datos clínicos \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Biopsia** SI  NO Fecha: \_\_\_/\_\_\_/\_\_\_\_ | | | | | | |
| **Terapia Antiviral** | SI  NO | Fecha de inicio de tratamiento: | | | | \_\_\_/\_\_\_/\_\_\_\_ |
| Especifique: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Terapia Supresora** SI  NO  Especifique: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Catéter Doble Jota** SI  NO  **MM** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Rechazo Reciente** SI NO *(dentro de los primeros 6 meses)* | | | | | | |
| **Muestra** | | | | | | |
| Fecha de toma : | | \_\_\_/\_\_\_\_/\_\_\_\_\_ | Nro. de protocolo: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Tipo de muestra: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Datos del Solicitante** | | | | | | |
| Efector solicitante: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Fecha de solicitud: | | \_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | |
| Firma y sello del médico: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Email: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Teléfono: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |