Затверджено

Наказ МОЗ України

10.01.2006 № 1

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|  | Назва міністерства, іншого центрального органу виконавчої влади, органу місцевого самоврядування, у сфері управління якого перебуває заклад \_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | **МЕДИЧНА ДОКУМЕНТАЦІЯ**  Форма первинної облікової документації  № 089-2/о  **ЗАТВЕРДЖЕНО**  Наказ МОЗ України | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | Найменування та місцезнаходження (повна поштова адреса) закладу, відповідальні особи якого заповнили повідомлення \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Ідентифікаційний код ЄДРПОУ | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | **ПОВІДОМЛЕННЯ**  про хворого з уперше в житті встановленим діагнозом трихофітії, мікроспорії, фавуса, корости | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  |  | | | | | | | | | | (дата заповнення) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | Повідомлення направлено до | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | (найменування закладу охорони здоров’я) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | 1. Прізвище, ім’я, по батькові хворого | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | 2. Стать: чоловіча – 1, жіноча - 2 | | | | | | | | | | | |  | | | 3. Вік | | | | | | | | | | | |  | | | | | | 4. Дата звернення (профогляду) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | |  | | | | | | |  | | | | | |  | | | | |  | |
|  | (число, місяць, рік) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | 5. Місце проживання хворого (поштова адреса): країна | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | область | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | район | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | | населений пункт | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
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|  | | вулиця | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | будинок № | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | кв. № | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
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|  | | 6. Місце роботи, навчання хворого | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | | 7. Діагноз захворювання | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | | 8. Дата встановлення діагнозу | | | | | | | | | |  | | | | | |  | | | |  | | | | | | | |  | |  | | | | |  | | | | |  | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  |
|  | |  | | | | | | | | | | (число, | | | | | | | | | | місяць, | | | | | | | | | | рік) | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  |
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|  | | 9. Діагноз установлено під час: звернення до лікаря – 1, профілактичного огляду – 2, обстеження в лікарні – 3, | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | | бстеження осіб, що перебували у контакті з хворим, – 4, інше – 5 (уписати) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | |  |
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|  | | 10. Діагноз підтверджено: лабораторним дослідженням – 1; клінічно – 2, | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | іншим – 3 (уписати) | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | | 11. Дата відправлення повідомлення | | | | | | | | | | | | | | | | | | | | „ | | | |  | | | | | | | | | ” | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20 | | | | | | | | | |  | | | | | | | | | | | | | | р. | | | | | | | | | | | |  |
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|  | | **Прізвище, ім’я, по батькові та** | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | **номер контактного телефону лікаря, який заповнив повідомлення** | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| **Начальник Центру**  **медичної статистики**  **МОЗ України** | **М.В. Голубчиков** |