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| DATOS PERSONALES | | | |
| Nombre: |  | Apellidos: |  |
| Madre/padre/Tutor: |  | Madre/Padre/Tutor: |  |
| Teléfono de contacto: |  | Móvil: |  |
| Dirección: |  | | |

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| INFORMACIÓN MEDICA | | | |
| Diagnóstico clínico: |  | | |
|  | SÍ | NO | OBSERVACIONES |
| ALERGIAS |  |  |  |
| CAMINA DE MANERA AUTÓNOMA |  |  |  |
| PADECE INCONTINENCIA |  |  |  |
| PROBLEMAS EN LA MASTICACIÓN/DEGLUCIÓN |  |  |  |
| SE COMUNICA DE MANERA AUTÓNOMA |  |  |  |
| LLEVA GAFAS |  |  |  |
| LLEVA PRÓTESIS AUDITIVA |  |  |  |

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| MEDICAMENTOS Y PAUTA DE ADMINISTRACIÓN | | | | | | | | | | |
| NOMBRE MEDICAMENTO | | MAÑANA | | TARDE | | NOCHE | | | OBSERVACIONES | |
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| DESEMPEÑO DE LAS ACTIVIDADES DE LA VIDA DIARIA | | | | | | | | | | |
|  |  | | TOTALMENTE  INDEPENDIENTE | | NECESITA MÍNIMA AYUDA | | NECESITA GRAN AYUDA | TOTALMENTE DEPENDIENTE | | OBSERVACIONES / ADAPTACIONES |
| ALIMENTACIÓN | COMER | |  | |  | |  |  | |  |
| BEBER | |  | |  | |  |  | |
| ASEO PERSONAL | PEINARSE | |  | |  | |  |  | |  |
| LAVARSE LA CARA/MANOS | |  | |  | |  |  | |
| LAVARSE LOS DIENTES | |  | |  | |  |  | |
| BAÑARSE | |  | |  | |  |  | |
| MICCIÓN / DEFECACIÓN | |  | |  | |  |  | |
| VESTIDO / DESVESTIDO | | |  | |  | |  |  | |  |
| DEAMBULACIÓN | MARCHA | |  | |  | |  |  | |  |
| TRANSFERENCIAS SILLA/CAMA | |  | |  | |  |  | |
| DESCANSO/ SUEÑO | | |  | |  | |  |  | |  |

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| CAMBIOS POSTURALES DURANTE LA NOCHE | SI | NO | LUZ PARA DORMIR | SI | NO |  |

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| OTROS DATOS DE INTERÉS |