**JUSTIFICATIVA PARA COMPRA/ EMPRÉSTIMO DE MEDICAMENTO NÃO PADRONIZADO**

|  |  |
| --- | --- |
| **PACIENTE:**  **RG:**  **CLÍNICA:**  **LEITO:**  **Se possível colar a etiqueta** | **Nome comercial:**  **Nome genérico:**  **Dose:**  **Apresentação:**  **Posologia:**  **Período de tratamento:** |

Justificativa técnica para a compra/empréstimo de medicamento não – padronizado, e informação quanto à discordância de substituição por medicamento similar ou equivalente padronizado:

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Nome do médico: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CRM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assinatura: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telefones para contato: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Enviar para a Diretoria do Serviço de Farmácia – Térreo prédio principal**