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| **NOMBRE DEL ÁREA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **NOMBRE DEL MÉDICO QUE ATIENDE LA CONSULTA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **SERVICIO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **TIPO: MÉDICO ( ) ENFERMERA ( )** | | | | | | | | | | | | | | |
| Fecha | No. | Nombre | Expediente | Edad | Sexo | 1ra vez (Diagnóstico) | Consecuente | Servicios | | | | Diagnóstico | Referido | Contrareferido |
| Fisioterapia | Nutrición | Odontología | Laboratorio Clínico |
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**Revisado y aprobado por: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MÉDICO DEPARTAMENTO BIENESTAR ESTUDIANTIL**