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| SOLICITUD DE REGISTRO PARA USO DE ESTUPEFACIENTES | | | | | | | | | | | | | | | | | | | | | | |
| **DATOS DEL PACIENTE** | | | | | | | | | | | | | | | | | | | | | | |
| Nombre: | |  | | | | | | | | | | | | | | | | | | | | |
| Dirección: | |  | | | | | | | | | | | | | | | | | | | | |
| Sexo: F M | | | | | | | | | Edad: | Años | | | | | Teléfonos: | | | | |  | | |
| Cédula de Vecindad o DPI: | | | | | | |  | | | | | Extendida en: | | | |  | | | | | | |
| Nombre del Representante (cuando aplique): | | | | | | | | | | |  | | | | | | | | | | | |
| Cédula de Vecindad o DPI: | | | | | | |  | | | | | | | Teléfonos: | | | |  | | | | |
| DIAGNÓSTICO Y TRATAMIENTO EFECTUADO | | | | | | | | | | | | | | | | | | | | | | |
| Diagnóstico Clínico: | | | |  | | | | | | | | | | | | | | | | | | |
| Tratamiento aplicado: | | | |  | | | | | | | | | | | | | | | | | | |
| Quirúrgico Radioterapia Hormonal Paliativo | | | | | | | | | | | | | | | | | | | | | | |
| **DATOS SOBRE EL PRODUCTO** | | | | | | | | | | | | | | | | | | | | | | |
| Estupefaciente solicitado: | | | | | |  | | | | | | | | | | | | | | | | |
| Presentación y concentración: | | | | | | | |  | | | | | | | | | | | | | | |
| Tiempo probable: | | |  | | | | | | | | | | Cantidad diaria: | | | | | |  | | | |
| Cuota semanal: | | |  | | | | | | | | | | Cuota mensual: | | | | | |  | | | |
| **DATOS DEL PROFESIONAL SOLICITANTE** | | | | | | | | | | | | | | | | | | | | | | |
| Nombre: |  | | | | | | | | | | | | | | | | Colegiado No. | | | | |  |
| Dirección de la Clínica: | | | | |  | | | | | | | | | | | | Teléfono: | | | |  | |
| **Firma del Profesional** | | | | | | | | | **Sello del Profesional** | | | | | | | | **Timbre Profesional** | | | | | |

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| **PARA USO DEL DEPARTAMENTO** | |
| **No. Registro asignado:** | **Fecha:** |