Приложение № 2

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|  |  | |  | | |
| (наименование медицинского учреждения) |  |  | | | |
|  |  | Медицинская документация | | | |
|  |  | Форма № 057/у-04 | |  |  |
|  |  |  | | | |
| (адрес)  Печать организации |  |

**НАПРАВЛЕНИЕ  
на госпитализацию, восстановительное лечение, обследование, консультацию**

(нужное подчеркнуть)

**ФГБУ СКФНКЦ ФМБА России**

(наименование медицинского учреждения, куда направлен пациент)

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| 1. Номер страхового полиса ОМС |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| 2. Код льготы |  |  |  |

3. Фамилия, имя, отчество \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Дата рождения \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Адрес постоянного места жительства \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Место работы, должность\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 7. Код диагноза по МКБ |  |  |  |  |  |  |

8. Обоснование направления:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Должность медицинского работника, направившего больного

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| (подпись) |  | (Ф.И.О.) |

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| Заведующий отделением | | | |  | | |  |  |
|  | | | | (подпись) | | |  | (Ф.И.О.) |
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М.П.