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| **Name/Vorname:** |  | **Geb.Dat.:** |  | **Gew.:** | kg | **Diagnose** |  |

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| **Arzt** | **Fixe Medikation****Medikament** | **Menge/****kg/****Dosis** | **Menge/****Dosis** | **Intervall** | **Appli-kation** | **Verabreichungszeit/Bemerkungen** | **STOP** |
| **Datum** | **Visum** | **Datum** | **Arzt** |
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| **Arzt** | **Reserve-Medikation****Medikament** | **Menge/****kg/****Dosis** | **Menge/****Dosis** | **Intervall** | **Appli-kation** | **Verabreichungszeit/****Bemerkungen** | **STOP** |
| **Datum** | **Visum** | **Datum** | **Arzt** |
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| **Kontakt für Rückfragen** |  |  | Stempel/Unterschrift Arzt: |
| Verordnender Arzt: |  |  |
| Tel. Nr.: |  |  |
| Email: |  |  |