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| Министерство здравоохранения  Российской Федерации | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | МЕСТО ДЛЯ ШТРИХКОДА <\*> | | | | | | | | | | | | | | Утверждена приказом Министерства  здравоохранения Российской Федерации  от 24 ноября 2021 г. N 1094н | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Штамп ЛПУШтамп | | | | | | |  | |  | | | |  | | |  | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Код  медицинской организации | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Штамп | | | | | | |  | |  | | | |  | | |  | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Код  индивидуального предпринимателя | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Код категории  граждан | | | | | | | | | | Код нозологической формы (по МКБ) | | | | | | | | | | | | | | | | | | | | | | | | | Источник финансирования:  (подчеркнуть)  1. Федеральный бюджет  2. Бюджет субъекта Российской Федерации  3. Муниципальный бюджет | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | % оплаты:  (подчеркнуть)  1. Бесплатно  2. 50%  3. иной % | | | | | | | | | | | | |
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| **РЕЦЕПТ** Серия \_\_\_\_\_\_\_\_ № \_\_\_\_\_\_\_\_\_\_\_ Дата оформления | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |  | | | | |  | | | |  | | | 20\_\_\_г. | | | | |
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| Фамилия, инициалы имени и отчества | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (последнее - при наличии) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| пациента | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Дата рождения | | | | | | | | | | |  | |  | |  | | |  | |  | | |  | | | | |  | |  | | |  | | |  | |  |
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| СНИЛС | | | | | | | | | | |  | | |  | | | | |  | | | |  | | | |  | | |  | | |  | |  | | | |  | | |  | | |  | | |  |  | |  | |  |  | |  | |  | | |  | | | |  | | | |  | | | |  | | |  | | |  | |  | | |
| № полиса  обязательного  медицинского  страхования | | | | | | | | | | |  | | |  | | | | |  | | | |  | | | |  | | |  | | |  | |  | | | |  | | |  | | |  | | |  |  | |  | |  |  | |  | |  | | |  | | | |  | | | |  | | | |  | | |  | | |  | |  | | |
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| Номер медицинской карты пациента, получающего медицинскую помощь | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| в амбулаторных условиях | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Фамилия, инициалы имени и отчества (последнее - при наличии) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| лечащего врача (фельдшера, акушерки) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ───────────────────────────────────────────────────────── | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Для рецептовРуб. | Коп. | Rp:  ……|.…….|……D.t.d…………………………………………………………………………………………  ……|.…….|……Signa:………………………………………………………………………………………. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ВрачПодпись и печать лечащего врача М.П.  (подпись фельдшера, акушерки) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Рецепт действителен в течение 15 дней, 30 дней, 90 дней (нужное подчеркнуть)  – – – – – – – – – – – – – – – – – – (Заполняется специалистом аптечной организации) – – – – – – – – – – – – – – – – – – | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Отпущено по рецепту: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Торговое наименование и дозировка: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Дата отпуска: «\_\_\_\_» \_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_г. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Количество: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Приготовил: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Проверил: Отпустил: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| – – – – – – – – – – – – – – – – – – – – – – – – – – – – – (линия отрыва) – – – – – – – – – – – – – – – – – – – – – – – – – – – | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Корешок рецептурного бланка  Наименование лекарственного препарата:  Дозировка: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Способ применения:  Продолжительность \_\_\_\_\_\_\_ дней  Количество приемов в день: \_\_\_\_\_ раз  На 1 прием: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ед. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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<\*> В случае изготовления рецептурного бланка с использованием компьютерных технологий.

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| Оборотная сторона |

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|  | Отметка о назначении лекарственного препарата по решению врачебной комиссии |
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| Приготовил | Проверил | Отпустил |
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