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IDENTIFICAÇÃO DO EMITENTE

NOME COMPLETO:
CRM: UF:
ENDEREÇO COMPLETO:

CIDADE: UF:
TELEFONE: DATA:



Logo do local de
atendimento
(imagem)

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DAS NEVES

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ASSINATURA MÉDICO(A)

NOME PACIENTE:

ENDEREÇO COMPLETO:

PRESCRIÇÃO:

IDENTIFICAÇÃO DO COMPRADOR

NOME COMPLETO:

RG:
ÓRGÃO EMISSOR:
ENDEREÇO COMPLETO:

CIDADE: UF:
TELEFONE:

IDENTIFICAÇÃO DO FORNECEDOR

NOME FARMACÊUTICO(A):

CRF: UF:
NOME FARMÁCIA:
ENDEREÇO:
CIDADE: UF:
CNPJ: TELEFONE:

ASSINATURA FARMACÊUTICO(A)

DADOS DO(S) PRODUTO(S) DISPENSADOS

NOME DO MEDICAMENTO: _____

LABORATÓRIO: _____

NÚMERO DO LOTE: _____ QUANTIDADE DE CAIXAS: _____

NÚMERO DE REGISTRO DA RECEITA NO LIVRO DE RECEITUÁRIO: _____
(QUANDO MEDICAMENTO MANIPULADO)

NOME DO MEDICAMENTO: _____

LABORATÓRIO: _____

NÚMERO DO LOTE: _____ QUANTIDADE DE CAIXAS: _____

NÚMERO DE REGISTRO DA RECEITA NO LIVRO DE RECEITUÁRIO: _____
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NÚMERO DE REGISTRO DA RECEITA NO LIVRO DE RECEITUÁRIO: _____
(QUANDO MEDICAMENTO MANIPULADO)

INFORMAÇÕES SOBRE INTERCAMBIALIDADE

O MEDICAMENTO _____
FOI SUBSTITUÍDO PELO GENÉRICO _____,
DE ACORDO COM A LEI 9787/99.

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O MEDICAMENTO _____
FOI SUBSTITUÍDO PELO GENÉRICO _____,
DE ACORDO COM A LEI 9787/99.

PARA DISPENSAÇÃO MANUAL

DATA: _____

ASSINATURA DO COMPRADOR: _____

ASSINATURA DO FARMACÊUTICO: _____

RELATÓRIO MÉDICO

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PACIENTE:

RELATÓRIO:

NOME DO(A) MÉDICO(A):

CRM:

UF:

LOCAL DE ATENDIMENTO:

CNES:

ENDEREÇO:

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DATA DE EMISSÃO:

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ASSINATURA MÉDICO(A)

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