**DECLARAÇÃO MÉDICA (JUNTAR COM O LAUDO)**

**Nome do Paciente**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Deficiência**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CID**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Declaro que este paciente precisa de um profissional especifico para:

( ) Locomoção mobilidade reduzida ( ) Cadeira de rodas ( ) Outros. Neste caso explique abaixo.

( ) Higiene pessoal ...fraldas ou impedimento físico para a higiene ( ) Outros. Neste caso explique abaixo.

O impedimento para se alimentar com autonomia é de ordem:

( ) Física ( ) Biológica ( ) Outros. Neste caso, explique abaixo.

Preenchimento do Médico

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São Paulo, \_\_\_\_\_\_ de \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ de 20 \_\_\_\_\_.

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**(Assinatura e carimbo do Médico)**