**แบบบันทึกการรักษา**

เสนอ คณะอนุกรรมการพิจารณาคำร้องขอรับเงินช่วยเหลือเบื้องต้น จังหวัดขอนแก่น

วันที่...........................................................................

ผู้ป่วยชื่อ.................................................................สกุล.................................................อายุ............................ปี

ที่อยู่......................................................................................................................................................................

ประวัติการเจ็บป่วยในอดีต/และครอบครัว............................................................................................................................................................................................................................................................................................................................................................

ประวัติการเจ็บป่วยปัจจุบัน.......................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................... ............................................................................................................................................................................................................................................................................................................................................................

การตรวจร่างกาย/X-ray....................................................................................................................................... ..............................................................................................................................................................................

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ผลการตรวจทางห้องปฏิบัติการ............................................................................................................................ ..............................................................................................................................................................................

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การวินิจฉัยโรค..................................................................................................................................................... ..............................................................................................................................................................................

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การรักษาที่ได้รับ................................................................................................................................................... ..............................................................................................................................................................................

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สรุปผลการวินิจฉัย/การรักษาและสาเหตุที่เสียชีวิต.............................................................................................................................................................................. ..............................................................................................................................................................................

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ลงนาม.................................................

(..................................................)

แพทย์ผู้ให้การรักษา

ลงนาม.................................................

(..................................................)

ผู้ตรวจสอบ

ลงนาม.................................................

(..................................................)

ผู้อำนวยการโรงพยาบาล

**หมายเหตุ** พร้อมรายละเอียดเวชระเบียนที่เกี่ยวข้องทั้งหมด