附件4

助医照顾服务汇总表

\_\_\_\_\_\_（区县）卫生健康委联系人**：** 联系电话： 填报日期：

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| 序号 | 姓名 | 性别 | 身份证号码 | 住址 | 承办机构 | 65周岁以上失能老年人 | | | | 联系电话 |
| 家庭医生签约服务 | 健康评估 | 康复护理指导等健康服务 | 免费体检 |
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| 备注：住址填写身份证上的详细住址；家庭医生签约服务、健康评估用“√”表示；康复护理指导等健康服务、免费体检次数用“数字”填报。 | | | | | | | | | | |