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| **Medikationsplan** |

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| **Name, Vorname:** | Bitte ausfüllen |  | **Größe:** | Bitte ausfüllen cm |
| **Geburtsdatum:** | Bitte Datum auswählen. |  | **Gewicht:** | Bitte ausfüllen kg |
| **Allergien/Unverträglichkeiten:** |        |  | **Datum:** | Bitte Datum auswählen. |
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| **Wirkstoff** | **Handelsname** | **Stärke** | **morgens** | **mittags** | **abends** | **zur Nacht** | **Grund** |
| *z.B. Ramipril* | *Delix®* | *5mg* | *1* | *0* | *0* | *0* | *Bluthochdruck* |
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| **Arzneimittel bei Bedarf** (z.B. Schmerzmittel, Schlafmittel, Abführmittel)**?****Präparate der Selbstmedikation** aus Drogerie oder Apotheke (z.B. pflanzliche Präparate, Vitamine)**?** |
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