**REGISTRO IBÉRICO – Estudio ReLoCC**

**Nombre IPL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ID Local** (Centro / Hospital): **ES - \_\_\_\_ \_\_\_\_ \_\_\_\_**

**Identificación del Paciente**: completar con los datos del paciente que se incluirán en el estudio.

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| **Paciente** | **Fecha de nacimiento** (dd/mm/aaaa) | **Fecha de consentimiento informado**  (dd/mm/aaaa) | **ID ReLoCC del paciente ( \_ \_- \_ \_ \_- \_ \_\_ )** |
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**Firma de IPL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Por favor complete y envíe a: diana.goncalves@chsj.min-saude.pt