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|-----------------------------------------|-----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> HME | <input checked="" type="checkbox"/> HGM | <input checked="" type="checkbox"/> HRV |
| <input type="checkbox"/> MCH | <input checked="" type="checkbox"/> MGH | <input type="checkbox"/> RVH |
| <input checked="" type="checkbox"/> HNM | <input checked="" type="checkbox"/> ITM | <input type="checkbox"/> CL |
| <input checked="" type="checkbox"/> MNH | <input type="checkbox"/> MCI | <input type="checkbox"/> LC |



PATIENTS EXTERNES / OUTPATIENT
FEUILLE DE ROUTE / FLOW SHEET

Sensation: _____ **Date:** _____
A A Y Y / M M / J D

Mois / Month:													
Jour / Day:													
Signature:													
À valuation:													
Soins de peau / cicatrice Skin care / scar													
Œdème / edema													
A.A.A. / AROM													
A.A.P. / PROM													
Orthèse / Orthosis													
Désensibilisation Desensitization													
AVQ / ADL													
Renforcement Strengthening													