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| **Ciudad: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Datos de la Víctima Directa** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primer Nombre** | | | | | | | **Segundo Nombre** | | | | | | | **Primer Apellido** | | | | | | | **Segundo Apellido** | | | | | | | | | | **Sexo** | | | | | | | | **Tipo de Documento** | | | | | | | | | | | | **Numero de Documento** | | | | |
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| Numero de Radicado ante la Unidad de Victimas:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Datos de la persona que solicita el servicio de salud** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primer Nombre** | | | | | | | | | **Segundo Nombre** | | | | | | | | **Primer Apellido** | | | | | | | **Segundo Apellido** | | | | | | | | | | | | | **Sexo** | | | | | | | | **Tipo de Documento** | | | | | | | **Numero de Documento** | | | |
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| **Estado civil** | | | | | **Fecha de Nacimiento** | | | | | | | | | | | **Edad** | | | **Etnia** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Parentesco con la victima directa** | | | | | | |
|  | | | | |  | | | | | | | | | | |  | | | **Afrocolombiano** | | | | | | | |  | | | **Negro** | | | | | |  | | | **Palenquero** | | | | | | | |  | |  | | | | | | |
| **Raizal** | | | | | | | |  | | | **Rrom** | | | | | |  | | | **Indigena** | | | | | | | |  | |
| **Discapacidad** | | | | | | | | | | | | Cual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | **Recibió algún tratamiento medico** | | | | | | | | | | | | | | | | | | | | Cual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| SI | |  | | NO | | | |  | | | | SI | | |  | | | | NO | | | | | | |  | | | | | |
| 1. **Datos de Contacto** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Municipio/Corregimiento/Vereda de residencia** | | | | | | | | | | | | | | | | | | | | **Dirección** | | | | | | | | | | | | **Teléfono** | | | | | | | | | | | **Celular** | | | | | | | | **E - Mail** | | | | |
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| 1. **Afiliación a Salud** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Afiliado / a** | | | | | | | | | | | **Nombre EPS** | | | | | | | | | | | | | | | | | **Régimen** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SI |  | | NO | | |  | | | | |  | | | | | | | | | | | | | | | | | Subsidiado | | | | | | | | | |  | | | | | | Contributivo | | | | | |  | | | De excepción | |  |
| 1. **Tipo de atención Requerida (marcar la opción con una X)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Atención Psicosocial a Nivel** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Atención en Salud Integral** | | | | | | | | | | | | | | |
| Individual | | | | | | | | | |  | | | Familiar | | | | |  | | | | Comunitaria | | | | | | | | | | |  | | | | | | | | Física | | | | | | |  | | | | | Mental |  | |
| 1. **Identificación de Barreras de Acceso (marcar la** | | | | | | | | | | | | | | | | | | | | | | | | | 1. **Motivo de la Remisión (Describa brevemente las razones)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **opción con una X)** | | | | | | | | | | | | | | | | | | | | SI | | | NO | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Demora en la asignación de citas | | | | | | | | | | | | | | | | | | | |  | | |  | |
| Dificultad en el desplazamiento para el acceso a servicios de salud (no entrega subsidio de transporte) | | | | | | | | | | | | | | | | | | | |  | | |  | |
| Demora en la autorización de servicios de salud | | | | | | | | | | | | | | | | | | | |  | | |  | |
| No entrega de medicamentos | | | | | | | | | | | | | | | | | | | |  | | |  | |
| En el sitio de residencia | | | | | | | | | | | | | | | | | | | |  | | |  | |
| Entrega incompleta | | | | | | | | | | | | | | | | | | | |  | | |  | |
| Problemas de afiliación por: | | | | | | | | | | | | | | | | | | | |  | | |  | |
| Encuesta Sisbén | | | | | | | | | | | | | | | | | | | |  | | |  | |
| Multiafiliación (Varias afiliaciones) | | | | | | | | | | | | | | | | | | | |  | | |  | |
| Demora en el reporte de novedades | | | | | | | | | | | | | | | | | | | |  | | |  | |
| 1. **Datos del funcionario que realiza la remisión:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nombre | | | | | | | | | | | | | | | Cargo | | | | | | | | | | | | | | | | | | | Entidad | | | | | | | | | | | | | | | | | | | | | |
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**CONTROL DE CAMBIOS**

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| **Versión** | **Fecha del cambio** | **Descripción de la modificación** |
| V1 | 14/08/2014 | Creación del formato. |
| V2 | 14/08/2017 | * Actualización por cambio del nombre del proceso de Gestión de Reparación Individual y Colectiva a Reparación Integral. * Actualización del formato por cambio del Procedimiento Control de Documentos. |