附件3

困难精神残疾人药费补助汇总表

埇桥区 乡镇（街道） 年 月 日

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 序号 | 姓名 | 残疾证号 | 性别 | 家庭住址 | 联系电话 | 家庭经济状况 | 开户名 | 银行账号 | 监护人姓名 | 监护人电话 | 与患者关系 |
| 1 |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |

**备注：表中残疾人联系电话和监护人联系电话可选填一个，需是有效电话，并能清楚回答回访的问题。**