

Request to Attending Physician

担当医へのお願い

1. Please fill in this form so that the patient may claim the social insurance benefit.
この様式は患者の社会保険の給付の申請に必要ですので、証明をお願いします。
2. This form should be completed and signed by the attending physician.
この様式は担当医が書き、かつ署名して下さい。
3. One form for each month and one form for hospitalization/outpatient (home visit) should be filled 各月毎、入院・入院外毎に付、この様式1枚が必要です。

Attending Physician's Statement

診療内容明細書

Form A

様式A

1. Name of Patient (Last, First) Age(Date of Birth) Sex(Male・Female)
患者名 _____ 年齢(生年月日) _____ 性別 _____

2. Name of Illness or Injury preferably with the number of International Classification of Diseases for the use of Social Insurance (Please refer to the table attached to this form).
傷病名及び社会保険用国際疾病分類番号 (P7~P10参照)

(No. _____)

3. Date of First Diagnosis

初診日 _____

4. Days of Diagnosis and Treatment

診療日数 _____ days

5. Type of Treatment

治療の分類

Hospitalization From _____ to _____ (_____ days)
入院 自 _____ 至 _____ (_____ 日間)

Outpatient or Home Visit _____ .
入院外 _____ .

6. Nature and Condition of Illness or Injury (in brief)

症状の概要

7. Prescription, Operation and any other Treatments (in brief)

処方、手術その他の処置の概要

8. Was the treatment required as a result of an accidental injury? Yes No

治療は事故の傷害によるものですか。

9. Itemized amounts paid to Hospital and / or Attending Physician : Fill in Form B

項目別治療実費

10. Name and Address of Attending Physician

担当医の名前及び住所

Name Last(姓) _____ First(名) _____ Title(称号) _____

Address Home(自宅) _____ Phone 電話 _____

Office(病院又は診療所)

Phone 電話

Date(日付)

Signature(署名)

Attending Physician(担当医)

Reference Number of your Medical Record (if applicable)

診療録の番号

様式A 邦訳

2. 傷病名及び社会保険用国際疾病分類番号

6. 症状の概要

7. 処方、手術その他の処置の概要

翻譯者

住所 _____

氏名 _____

電話 _____