診療録の番号

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 health insurance benefit. この様式は患者の健康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記入し、かつ署名してください。
- 3. One form for each month and one form for hospitalization / outpatient (home visit) should be filled out. 各月毎,また入院・入院外毎につき,この様式1枚が必要です。

Attending Physician's Statement 診療内容明細書

1.	Name of Patient (Last,First) 患者名	Date of bir 生年月日	rth /	/	Sex (性別(Sex (Male·Female) 性別(男・女)		
2.	Name of Illness or Injury preferably with the number of International Classification of Disease for the use of Health Insurance. (Please refer to the table attached to this form.) (No.)							
3.	Date of first Diagnosis 初診日/							
4.	Days of Diagnosis and Treatment: 診療日数	days 日						
5.	Type of Treatment 治療の分類 □Hospitalization: From 入院 自 / □Outpatient or Home Visit 入院外 / / ,						days) 日間) /	
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 a 医療機関,または担当医に支払った				Fill in Fo	rm B		
10	. Name and Address of Attending Pl 担当医の名前及び住所	hysician						
	Name Last(姓)	First(名)		Title(称号)				
	Address Home(自宅)				Phone(Phone(電話)		
	Office(病院または診療所)			-	Phone			
	Date(日付)/ Sig	nature(署名))					
					Attendi	ng Phys	ician(担当医	
	Reference Number of your Medic	cal Record (if applic	able)				

2.	傷病名
6.	症状の概要
7.	処方、手術その他の処置の概要
	### ≅ □ ±V
	翻訳者
	氏名

電話_____