Form A 様式A

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、入院・通院毎につき、この様式１枚が必要です。

Attending Physician's Statement 診療内容明細書（医科）

1. Name of Patient(Last,First) 患者名 ....

2. Age(Date of Birth) 年齢(生年月日) .... Sex(Male･Female) 性別(男･女)

3. Name of Illness or Injury preferably with the number of International of 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(附録参照) ※要邦訳(裏面)

   ....(No.)

4. Date of First Diagnosis 初診日 ....

5. Days of Diagnosis and Treatment 診療日数 ....days

6. Type of Treatement 治療の分類
   ○Hospitalization 入院 From .... to .... days
   ○Outpatient or Home Visit 外来 ....
   ....

7. Nature and Condition of Illness or Injury(in brief) 症状の概要 ※要邦訳(裏面)

   ....

8. Prescription,operation and any other treatment(in brief) 処方、手術その他処置の概要
   .... ※要邦訳(裏面)

9. 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。 はい いいえ

10. Itemized amounts paid to Hospital and / or Attending Physician. ：Fill in Form B
    項目別治療実費 様式Ｂによる

11. Name and Address of Attending Physician 担当医の名前と住所
    Name 名前 ： Last 姓 .... First 名 .... Tittle 称号 ....
    Address 住所 ： Home 自宅 .... Phone 電話 ....
    Office 病院･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........................