

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 out. 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 (男 · 女)
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 (別添社会保険用国際疾病分類表参照)

3. Date of First Visit _____ (No. _____)
初診日 _____
4. Give Date of Treatment and Type of Treatment Rendered
治療の期日と治療の分類
 Out patient _____ (TOTAL _____ days)
外来 (治療日数) _____ , _____ , _____ , _____
 Home visit _____ (TOTAL _____ days)
往診 (治療日数) _____ , _____ , _____ , _____
 Date admitted _____ Date discharged _____
入院年月日 _____ ~ 退院年月日 _____
5. Nature and Condition of Illness or Injury (in brief)
症状の概要 _____

6. Prescription, Operation and any other Treatments (in brief) 処方、手術その他の処置の概要
 Prescription 処方
Internal medicines 内服
Medicine's Name _____ The days of prescription _____ days
薬品名 _____ 投与日数 _____
Medicines for external application 外用
Medicine's Name _____ The days of prescription _____ days
薬品名 _____ 投与日数 _____
A dose 頓服
Medicine's Name _____ The days of prescription _____ days
薬品名 _____ 投与日数 _____

Operation _____
手術 _____

Any other Treatments _____
その他の処置 _____

7. 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

8. 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

9. Name and Address of Attending Physician
担当医の名前及び住所

Name: Last _____ First _____ Title _____
名前: 姓 _____ 名 _____ 称号 _____

Address: Home _____ Phone _____
住所: 自宅 _____ 電話 _____

Office _____ Phone _____
病院又は診療所 _____ 電話 _____

Date: _____ Signature _____
日付 _____ 署名 _____

Attending Physician 担当医
Reference Number of your Medical Record (if applicable)

診療録の番号 _____