

Request to Attending Physician
担当医へのお願い

1. Please fill in 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 _____ Sex(Male . Female)
患者名 年齢 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 (別添参照)

_____ (No. _____)
3. Date of First Diagnosis: _____ , _____ , 20____
初診日
4. Days of Diagnosis and Treatment: _____ days
診療日数 日間
5. Type of Treatment
Hospitalization: From _____ , _____ to _____ , _____ (days)
入院 自 至 (日間)
Outpatient or Home Visit From _____ , _____ to _____ , _____ (days)
入院外 自 至 (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 はい いいえ
9. 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
10. Name and Address of Attending Physician 担当医の名前及び住所
Name 名前 : Last 姓 _____ First 名 _____ Title 称号 _____
Address 住所 : 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 _____