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 National Health insurance benefit. この様式は患者の国民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書き、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.毎月毎、入院・入院外毎につき、この様式が 1 枚必要です。

Form A Attending Physician's Statement								
	様式A 診療	内 容	明	細	書			
1.	Name of Patient (Last , First) Age (Date	e of Birth)		Sex (M	lale · Fem	ıale)		
	患者名 年齢(生年月日)				男・女)_			
2.	Name of Illness or Injury preferably with Number of International Classification of							
	diseases for the use of National Health Insurance (See the other side of this form)							
	傷病名及び国民健康保険用国際疾病分類番号			裏面参照	震)			
3.	Date of First Diagnosis : _ D / M / Y				/			
	初診日							
4.	Duration of Treatment:	lays						
	診療日数日	日						
5.	Type of Treatment							
	治療の分類							
	☐ Hospitalization: From		, to	/	/	_(days)	
	入院 自		,至 <u> </u>			_(日間)	
	\square Out patient or Home Visit :	/ /		/		_		
	入院外					_		
6.	6. Nature and Condition of Illness or Injury (in brief)							
	症状の概要							
7.	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 治療は事故の傷害によるものですか。	accidental inj	jury ?		No□ いいえ			
9.	Itemized Amounts paid to Hospital and/or Attending Physician: Form B 治療実費 様式B							
10.	Name and Address of Attending Physician 担当医の名前及び住所							
	Name 名前 : <u>Last 姓</u>	First 名		Ti	tle 称号			
	Address 住所 : <u>Home 自宅</u>			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 ______