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、かつ署名してください。
3. *One form for each month and one form for hospitalization / outpatient (home visit) should be filled out.*
   各月、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

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.
   傷病名および社会保険用国際疾病番号

   _____ (No.)
3. Date of First Diagnosis : (____ / ____ / ____)
   初診日　DD MM YY
4. Days of Diagnosis and Treatment : _____ days
   診療日数　日間
5. Type of Treatment
   治療の分類
   ☐ Hospitalization : From _____ to _____, for _____ days
   入 院　自　至　日間
   ☐ Outpatient or Home Visit : From _____ to _____, for _____ 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。
9. Itemized amounts paid to Hospital and / or Attending Physician : Please fill in Form B
   項目別治療実費
10. Name and Address of Attending Physician
    担当医の名前および所在地

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

    Address : Office _____ Phone _____
    病院または診療所の所在地　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 _____