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. この用紙は、患者の国民健康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. この用紙は、担当医師が書き、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. この用紙は、各月ごと、入院、入院外ごとに一枚必要です。

Attending Physican's Statement 診療内容明細書

1. Name of Patient (Last, First)	Age (Date of Birth)			Sex (Male·Female) 性別(男·女)			
患者名	_ 年齢(生年月日)						
2. Name of Illness or Injury prefera	bly with the Nu	oly with the Number of International Classification of diseases for the use					
National Health Insurance (See	the attached p	oaper)					
傷病名及び国民健康保険用国	際疾病分類番	号(別紙参照))				
				(No.)	
3. Date of First Diagnosis:	D/	M/	<u>Y</u>				
初診日	日/	月/	——年				
4. Days Diagnosis and Treatment:	day	ys					
診療日数	月	間					
5. Type of Treatment 治療の分類	į						
☐ Hospitalization: From	/ /	, to	/	/	(days)	
7 7	/	至	/	/	_ (日間)	
入院 自/_							
		/	/	/			
		/	/	/			
☐ Outpatient or Home Visit:	/ /		/	/			
□ Outpatient or Home Visit: 入院外 5. Nature and Condition of Illness of the State of the S	/ / or Injury (in br	/ rief)症状の概 ents (in brief)	/ 接 処方、手術-		置の概要	THY	
Outpatient or Home Visit:	or Injury (in br	/ rief)症状の概 ents (in brief)	/ 受 処方、手術- y? Yes□	No□	置の概要	7H	
Outpatient or Home Visit: 入院外 Nature and Condition of Illness Prescription, Operation and Any Nature and Condition of Illness	or Injury (in brown other treatments) of an action of an action of an action of action of the control of the c	/ rief)症状の概 ents (in brief) ccidental injur	/ 近要 処方、手術- y? Yesロ はい	No□ いいえ	置の概要	THY.	
Outpatient or Home Visit: 入院外 3. Nature and Condition of Illness 7. Prescription, Operation and Any 8. Was the treatment required as a 治療は事故の障害によるもので 9. Itemized Amounts paid to Hospi	or Injury (in brown other treatments) of an action of an action of an action of action of the control of the c	/ rief)症状の概 ents (in brief) ccidental injur	/ 近要 処方、手術- y? Yes□ はい tian: Fill in I	No□ いいえ Form B.	置の概要	ti-C	
Outpatient or Home Visit: 入院外 S. Nature and Condition of Illness 7. Prescription, Operation and Any 8. Was the treatment required as a 治療は事故の障害によるもので 9. Itemized Amounts paid to Hospi 項目別治療実費	/ or Injury (in br y other treatment a result of an action of the actio	rief)症状の概ents (in brief)	/ 近要 処方、手術- y? Yes□ はい sian: Fill in I 様式B	No□ いいえ	置の概要	i l i.	
コ Outpatient or Home Visit: 入院外 3. Nature and Condition of Illness 7. Prescription, Operation and Any 8. Was the treatment required as a 治療は事故の障害によるもので 9. Itemized Amounts paid to Hospi 項目別治療実費 10. Name and Address of Attending	/ // or Injury (in br y other treatments) a result of an action in the state of the state	/ hief) 症状の概 ents (in brief) ccidental injur tending Physic	/ 近要 処方、手術- はい tian: Fill in I 様式B ひで住所	No□ いいえ Form B. に記入			
Outpatient or Home Visit: 入院外 3. Nature and Condition of Illness 7. Prescription, Operation and Any 8. Was the treatment required as a 治療は事故の障害によるもので 9. Itemized Amounts paid to Hospi 項目別治療実費 10. Name and Address of Attending Name 名前 : Last 姓	/ or Injury (in brown or	rief)症状の概ents (in brief) ccidental injurtending Physical当医の名前及First 名	/ 短要 処方、手術- y? Yes□ はい sian: Fill in I 様式B ひび住所	No口 いいえ Form B. に記入 Title オ	弥号		
Outpatient or Home Visit: 入院外 3. Nature and Condition of Illness 7. Prescription, Operation and Any 3. Was the treatment required as a 治療は事故の障害によるもので 9. Itemized Amounts paid to Hospi 項目別治療実費 10. Name and Address of Attending Name 名前 : Last 姓 Address 住所: Home 自宅	/ or Injury (in brown or	rief)症状の概ents (in brief) ccidental injur tending Physic	/ 短要 処方、手術- 以字 Yes□ はい sian: Fill in I 様式B なび住所	No口 いいえ Form B. に記入 Title 和			
Outpatient or Home Visit: 入院外 3. Nature and Condition of Illness 7. Prescription, Operation and Any 8. Was the treatment required as a 治療は事故の障害によるもので 9. Itemized Amounts paid to Hospi 項目別治療実費 10. Name and Address of Attending Name 名前 : Last 姓	/ or Injury (in brown or	rief)症状の概ents (in brief) ccidental injur tending Physic	/ 短要 処方、手術- 以字 Yes□ はい sian: Fill in I 様式B なび住所	No口 いいえ Form B. に記入 Title stone 電話	弥号		

診療録の番号

様式A 翻訳

2.	傷病名及び国民健康保険用国際疾病分類番号
	傷病名
	国民健康保険用国際疾病分類番号
6.	症状の概要
7.	処方、手術その他の処置の概要
	翻 訳 者 住 所
	氏 名
	電話番号