【Form A】

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 should be filled out.
   各月毎、入院・外来毎にこの様式1枚が必要です。

Attending Physician's Statement
診 療 内 容 明 細 書

1. Name of Patient 患者氏名 _____. Date of Birth 生年月日 ____/____/____. Sex (Male・Femaile) 性別(男・女)

2. Name of Illness or Injury 傷病名 _____.

3. Data of First Diagnosis: 初診日 ____/____/____ .

4. Days of Diagnosis and Treatment: _____days
   診療日数

5. Type of Treatment
   治療の分類
   ☐ Hospitalization: From ____/____/____ to ____/____/____. (____days)
   入院
   ☐ Outpatient: ____/____/____ , ____/____/____ , ____/____/____ .
   外来

6. Nature and Condition of Illness or Injury 症状の概要

_____

7. Prescription,Operation and any other Treatments 処方、手術その他の処置の概要

_____

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

Name _____

Office Address _____

Phone _____

Date ____/____/____ Signature _____