Form A

Attending Physicians Statement

診療内容明細書

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 Number of International Classification of diseases for the use National Health Insurance (See the attached paper)
傷病名及び国民健康保険用国際疾病分類番号（添付書類参照）

3. Date of First Diagnosis : D / M / Y　____/____/____
初診日　**日/月/年**　____/____/____

4. Duration of Treatment : _____days
診療日数_____**日**

5. Type of Treatment
治療の分類
□ Hospitalization : From ____/____/____ , to ____/____/____ (　days)
入院　**自** ____/____/____ **至** ____/____/____ (　**日間)**
□ Out patient or Home Visit : ____/____/____　____/____/____
入院外　____/____/____　____/____/____

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 : 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**　：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_____