用紙C－9号(平成23.10)

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. 各月毎、入院・入院外毎につき、この様式1枚が必要です。

翻訳者

氏名

住所

Tel.

Form A 様式A Attending Physician's 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 the number of International Classification of Diseases for use of Social Insurance (Please refer to the table attached to this form).
   傷病名及び社会保険用国際疾病分類番号

   _____(No.)

3. Date of First Diagnosis: _____, 20_____
   初診日

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 _____, 20_____ (days)
   入院　自　至　(日間)

   ☐ Outpatient or Home Visit _____, _____ _____, 20_____
   入院外 _____, _____ _____, 20_____

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

   Name 氏名：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 Report(if applicable)
   診療録の番号 _____