

## Request to the Attending Physician

担当医へのお願い

- Please fill out this form so that the patient may claim health insurance benefits.  
この様式は患者の健康保険の給付の申請に必要ですので、証明をお願いします。
- This form should be completed and signed by the attending physician.  
この様式は担当医が記入し、かつ署名してください。
- One form for each month, and for each hospitalization / outpatient visit (home visit) should be filled out.  
各月毎、また入院、入院外毎につき、この様式 1 枚が必要です。

Form A  
様式 AAttending Physician's Statement  
診療内容明細書

## 1. Name of Patient (Last, First)

患者名 \_\_\_\_\_

Date of Birth ( D / M / Y )

生年月日 \_\_\_\_\_ . \_\_\_\_\_ . \_\_\_\_\_

Sex

性別

Male

• Female

Medical Record Number 診療録番号

\_\_\_\_\_

2. Name of Illness or Injury, Preferably with the International Classification of Diseases Number  
For Health Insurance Purposes. (Please refer to the table attached to this form.)

傷病名及び健康保険用国際疾病分類番号 (No. \_\_\_\_\_ )

## 3. Date of Initial Visit ( D / M / Y )

初診日 \_\_\_\_\_ . \_\_\_\_\_ . \_\_\_\_\_

## 4. No. Days of Visit/Treatment

診療日数 \_\_\_\_\_ days

## 5. Type of Treatment

治療の分類 ( D / M / Y )

☐ Hospitalization From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ days)  
入院 自 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 至 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ 日間)

☐ Outpatient or Home Visit \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ . \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
入院外 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ . \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## 6. Nature of Illness or Injury (in brief)

病状の概要

## 7. Prescription, Operation and Any Other Treatments (in brief)

処方、手術その他の処置の概要

8. Was treatment required as a result of accidental injury? \_\_\_\_\_ ☐ Yes ☐ No

治療は事故の傷害によるものですか？

## 9. Breakdown of Medical Expenses Paid to Hospital and / or Attending Physician : Please fill out Form B

医療機関、または担当医に支払った医療費の内訳：様式 B による

## ATTENDING PHYSICIAN INFORMATION 担当医情報欄

Medical Institution Name: (医療機関名)

Address: (住所)

Name of Physician: (担当医名)

Title: (称号)

Signature: (署名)

Phone: (電話)

Date Completed: (作成年月日)

2. 傷病名及び健康保険用国際疾病分類番号

\_\_\_\_\_

6. 病状の概要

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. 処方、手術その他の処置の概要

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

翻訳者

住所 \_\_\_\_\_

\_\_\_\_\_

氏名 \_\_\_\_\_ 印

電話 \_\_\_\_\_