Form A

Attending Physician's Statement

診 療 内 容 明 細 書

One form for each month and one for hospitalization / outpatient(home visit)should be filled out.
各月毎、入院･入院外毎に、この様式１枚が必要です。
This form should be completed and signed by the attending physician.
この様式は担当医が記入し、署名してください。

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 Medical System for the Elderly (See the other side of this form)
傷病名及び後期高齢者医療制度用国際疾病分類番号

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＿＿＿＿＿＿＿＿