

Form 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 Number of International Classification of diseases
for the use of Medical Welfare for Very Elderly (See the attach documents)
傷病名及び後期高齢者医療制度用国際疾病分類番号 (別紙参照)
- 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 _____