Request to Attending physician

担当医へお願い

- 1. Please fill in this form so that the patient may claim the National Health insurance benefit. 国民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。
- $2. \hspace{0.5cm} \mbox{This form should be completed and signed by the attending physician.}$

担当医が記入し、署名してください。

3. One form for each month and one for hospitalization / outpatient(home visit) should be filled out. 各月ごと、入院・入院外ごとに、1枚ずつ必要です。

Attending Physician's Statement

診療内容明細書

Name of patient	Age (Date of Birth)	Sex (Male · Female
_	年齢(生年月日) <u>n/</u>	
	ury preferably with the Number of	
	National Health Insurance (See the at 国際疾病分類番号 (別紙参照)	tached paper)
Date of First Diagnosis		_
	Treatment 診療日数:days	
Type of Treatment 治療の	分類	
☐ Hospitalization: Fro	$m \underline{D} / M / Y$, to \underline{D} / D	<u></u>
入院		(日間
☐ Out patient or Hon	ne Visit :y	
入院外	D/M/Y	<u>D</u> <u>M</u> <u>Y</u>
入院外		<u>D</u> <u>M</u> <u>Y</u>
入院外 Nature and Condition of Ill Prescription, Operation and Was the treatment requi	ness or Injury (in brief) 症状の概要 d Any other treatments (in brief) 処方、手 red as a result of an accidental injury:	術その他の処置の概要 ? Yes 🗆 No 🗆
入院外 Nature and Condition of Ill Prescription, Operation and Was the treatment requi	ness or Injury (in brief) 症状の概要 Any other treatments (in brief) 処方、手 red as a result of an accidental injury:	術その他の処置の概要 ? Yes □ No □ はい いいえ
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Reference Number of your Medical Record (if applicable) 診療録の番号