

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、この様式が1枚必要です。

Form A  
様式 A

Attending Physicians Statement  
診療内容明細書

1. Name of patient (Last, First) \_\_\_\_\_  
患者名  
Age (Date of Birth) \_\_\_\_\_ Sex (Male, Female)  
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 the use of Social Insurance (Please refer to the table attached of this form).  
傷病名及び社会保険用国際疾病分類番号 (別紙参照)  
\_\_\_\_\_ (No. \_\_\_\_\_)
3. Date of First Diagnosis : \_\_\_\_\_, 20\_\_\_\_\_  
初診日
4. Days or Diagnosis and Treatment : \_\_\_\_\_ days  
診療日数 \_\_\_\_\_ 日間
5. Type of Treatment  
治療の分類  
 Hospitalization : From \_\_\_\_\_, 20\_\_\_\_\_, to \_\_\_\_\_, 20\_\_\_\_\_ (days)  
入院 自 \_\_\_\_\_ 至 \_\_\_\_\_ (日間)  
 Out patient or Home Visit : \_\_\_\_\_, 20\_\_\_\_\_, \_\_\_\_\_, 20\_\_\_\_\_  
入院外 \_\_\_\_\_, 20\_\_\_\_\_, \_\_\_\_\_, 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. Itemized amounts paid to Hospital and / or Attending Physician : Fill in Form B  
項目別治療実費 様式 Bによる
10. Name and Address of Attending Physician  
担当医の名前と住所  
Name 名前 : Last 姓 \_\_\_\_\_ First 名 \_\_\_\_\_  
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 \_\_\_\_\_

## ■邦訳(A)

2. 傷病名及び社会保険用国際疾病分類番号

6. 症状の概要

7. 処方、手術その他の処置の概要

翻訳者記入欄	
名前	⑩
住所	電話