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 Long-term Care Insurance (See the attach documents) 傷病名及び国民健康保険用国際疾病分類番号(別紙参照)	Î
3.	Date of First Diagnosis: D / M / Y / / / / / / / / / / / / / / / / / / /	
4.	Duration of Treatment:days 診療日数日	
5.	Type of Treatment 治療の分類	
	□ Hospitalization: From	
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 : <u>Home</u> 自宅 <u>phone</u> 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	