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 National Health Insurance (See the other side of this form)
傷病名及び国民健康保険用国際疾病分類番号
_____ (No.)

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：Fill in 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 _____