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（裏面参照）

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 様式第27号

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＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿