

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 National Health Insurance  
 傷病名及び国民健康保険用国際疾病分類番号

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 \_\_\_\_\_