## 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
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: / / / / / / / / / / / / / / / / / / /
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 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