Attending Physician's Statement 診療内容明細書

1.	Name of Patient (Last, First) 患者名		th) Sex (Male·Female) 性別(男・女)	
2.	Name of Illness or Injury preferably with Number of International Classification of diseases for the use of elderly medical care system (See the attach documents) 傷病名及び後期高齢者医療制度用国際疾病分類番号(別紙参照)			
3.	Date of First Diagnosis: _ 初診日	D / M / Y 日 / 月 / 年		-
4.	Duration of Treatment: 診療日数	days 日		
5.	Type of Treatment 治療の分類 □Hospitalization: From 		/ / (
6.	Nature and Condition of Illne 症状の概要	ess or Injury (in br	ief)	
7.	Prescription, Operation and An 処方、手術その他の処置の概要	ny other treatments (in brief)	
8.	Was the treatment required as 治療は事故の傷害によるものですか。			□ No□ 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 担当医の名前及び住所	; Physician		
	Name名前 : <u>Last姓</u>	First名	Title称号	
	Office病院又は診療所 phone電話			
	Date日付:		 Attending Physician担当	 医
	R	Reference Number of y 診療録の番号	our Medical Record (i	f applicable)