

1.This form is used for claiming the RENESAS health insurance society benefit.
 2.This form should be completed and signed by the attending physician.

ATTENDING PHYSICIAN'S STATEMENT
 診療内容明細書

Name of Patient (患者名)		Date of Birth (生年月日)	Sex (性別) Male Female
Date of First Diagnosis (初診日) _____, 20____	Days of Diagnosis _____ days.	Diagnosis/Symptoms (診断/症状)	
Type of Treatment (治療の分類) <input type="checkbox"/> Hospitalization (入院) <input type="checkbox"/> Outpatient or Home Visit (入院外)		From _____, 20____	To _____, 20____ (days)

Description of Service (診療内容)	Fee (料金)
1. Consultation (診療)	
2. Medication (投薬)	
3. Injection (注射) <input type="checkbox"/> Injection (注射) <input type="checkbox"/> IV Treatment (点滴)	
4. Laboratory (検査)	
5. Hospitalization (入院)	
6. Operation (手術)	
7. Radiology (画像診断) <input type="checkbox"/> X-ray (レントゲン) <input type="checkbox"/> Ultrasound (超音波) <input type="checkbox"/> Nuclear Scan (核医学診断)	
8. Anesthesia (麻酔) <input type="checkbox"/> Local (局部) <input type="checkbox"/> Spinal (脊髄) <input type="checkbox"/> General (全身)	
9. Others (Specify) その他(項目明記)	

Name and Address of Attending Physician/Superintendent of Hospital or Clinic	Total Fee 合計
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Name: _____
 Address: _____
 Date: _____ Signature: _____