運動器損傷給付金のご請求の場合は、運動器損傷証明書をご使用ください。

To:Sumitomo Life Insurance Company

English Only:Please type or write in block letters.

ATTENDING PHYSICIAN'S STATEMENT 英文診断書(入院･手術･通院証明書)

■1.PATIENT'S NAME	■2.SEX ☐ M. ☐ F.	■3.DATE OF BIRTH (Month) (Day) (Year) ／ ／
■4.NAME OF SICKNESS OR INJURY FOR HOSPITALIZATION		■5.INCEPTION DATE OF SICKNESS OR INJURY (Month) (Day) (Year) ／ ／
		■6.CAUSE OF THE HOSPITALIZATION

■7. TREATMENT TERM

Intial Consultation： ／ ／ to ／ ／ Consultation：☐ Finish ☐ Continue

	Month	Day	Year		Month	Day	Year
1 st hospitalization	／	／		to	／	／	
2 nd hospitalization	／	／		to	／	／	

■8.SURGICAL OPERATION EFFECTED

※Important：Please circle appropriate

○	Craniotomy	○	Trepanation	○	Thoracotomy	○	Thoracoscopic Surgery
○	Laparotomy	○	Laparoscopic Surgery				
○	Operation using a fiberscope or a basket-lipvascular catheter on the brain,larynx,thoracic organs, and abdominal organs(excluding diagnostic procedures and temporary treatment)						
○	Others						

NAME OF OPERATION	DATE OF OPERATION Month ／ Day ／ Year

■9.RADIOTHERAPY	Place	Period ／ ／ to ／ ／
	Quantity in total	Gy（Rads)

■10. IN CASE OF MALIGNANT NEOPLASM

Result of Histopathological Diagnosis	☐(Yes) ☐(No)	Please describe the Name of Histopathological Diagnosis	TNM Staging	T( )N( )M( )
			Date of Diagnosis	／ ／ (Month)(Day)(Year)
		☐ Positive ☐ Negative	☐ Carcinoma in situ ☐ Invasive cancer	
Malignancy was Informed to:	Patient	Informed ☐(Yes) ☐(No)	Informed Name of Disease： On month ／Day ／Year	
	Family	Informed ☐(Yes) ☐(No)	Informed Name of Disease： To(Name of family：) On month ／Day ／Year	

■11. IN CASE OF ACUTE MYOCARDIAL INFARCTION	60 days after the initial consultation,was it still necessary to continue limiting the work done by the patient?('limiting the work'here refers to a state whereby the patient can do sedentary or light work but restrictions are necessary regarding moredemanding activities)	Yes／No	
■12. IN CASE OF CEREBRAL A POPLEXY	CNS sequelae remaining 60 days after initial consultation	Yes／No	If Yes,please write details of these sequelae

■13. TREATMENT RECEIVED AS OUTPATIENT

Treatment received in	Please circle day(s) of ambulatory care or visit for above■4(Disease/injury)-within 120days after discharge.	Total
Month /Year	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Day(s)
Month /Year	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Day(s)
Month /Year	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Day(s)
Month /Year	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Day(s)
Month /Year	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Day(s)

these statements are true and complete to the best of my knowledge and belief

Name of hospital

Date ／ ／ (Month) (Day) (Year)

Address of hospital

Signature of doctor

Country