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ATTENDING PHYSICIAN'S STATEMENT（入院・手術・通院　証明書）

To MeijiYasuda Life Insurance Company

Please type or write in block letters,and circle the appropriate number/items.

1 . Name of patient		Medical Chart No.	Sex: Male / Female	Date of birth	／ ／ month day year

2 . Name of Disease and / or Injury		Date of Onset (Physician's opinion)	
(a). Name of Disease / Injury for Hospitalization(operation)		／ ／ month day year	(e).(Patient is female only) Is she pregnant? Yes No If yes, Pregnancy week : ______ as of ／ ／ month day year
(b). Cause of the above(a)		／ ／ month day year	
(c). Complications		／ ／ month day year	
(d). Initial Consultation	／ ／ month day year	Final Consultation　Under Treatment	

3 . Previous Physician or Referring Physician	Yes / No	Name of Physician and Medical Institution	Period of Treatment from ／ ／ month day year ～ till ／ ／ month day year
4 . Past History and Chronic Disease	Yes / No	Name of Disease and Medical Institution,etc.	Period of Treatment from ／ ／ month day year ～ till ／ ／ month day year

5 . Period of hospitalization			
	1st	from ／ ／ month day year ～ till ／ ／ month day year	Inpatient / Discharged
	2nd	from ／ ／ month day year ～ till ／ ／ month day year	Inpatient / Discharged

6 . Description of the course of Disease/Injury since the initial consultation.

（Please describe in detail）

7 . Please fill in all of the Operations that was performed on the Disease / Injury（Including splinting or casting, sustainable drainage, endoscopic hemostasis, PTCD, stenting, TAE, tracheotomy）

	Surgical Procedure	Side	Name of Disease / Injury for Operation	Date of operation（Date of fixation）
1st		Left Right Both Other		／ ／ month day year
Type	① Craniotomy ② Trepanation ③ Thoracotomy ④ Thoracoscopic surgery ⑤ Laparotomy ⑥ Laparoscopic surgery ⑦ Transurethral operations ⑧ Transvaginal operations ⑨ Fiberscopic surgery or surgical catheterization for limbs ⑩ Fiberscopic surgery or surgical catheterization(excluding for limbs) ⑪ Operations on the eyeballs utilizing laser or cryopexy ⑫ Others (　　)			
Details	1. Open surgery　Closed surgery		3.In case of Extremity,was operative site MP Joint or more proximal? Yes No	
	2.Did the procedure require manipulation of Muscles or Bones? Yes No		4.In case of Dermatoplasty,grafts or flaps cover 25㎠ or larger　smaller than 25㎠ (*1)	
2nd		Left Right Both Other		／ ／ month day year
Type	① Craniotomy ② Trepanation ③ Thoracotomy ④ Thoracoscopic surgery ⑤ Laparotomy ⑥ Laparoscopic surgery ⑦ Transurethral operations ⑧ Transvaginal operations ⑨ Fiberscopic surgery or surgical catheterization for limbs ⑩ Fiberscopic surgery or surgical catheterization(excluding for limbs) ⑪ Operations on the eyeballs utilizing laser or cryopexy ⑫ Others (　　)			
Details	1. Open surgery　Closed surgery		3.In case of Extremity,was operative site MP Joint or more proximal? Yes No	
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8 . Radiotherapy, etc.	Curative radiotherapy / Hyper-thermotherapy	Region	Period	from month ／ day ／ year ～ till month ／ day ／ year	Total dose Gy

9 . Pathological study and Imagings				
	Histopathological Diagnosis		Date of Diagnosis	／ ／ month day year
	Imagings and cytology	① Cytodiagnosis ② Endoscopy ③ CT／MRI ④ Ultrasound examination ⑤ Others（　　）	Examination Date	／ ／ month day year
			Diagnostic impression	

10. In case of Malignant Neoplasm				
	Type	① Non-invasive carcinoma or intraepithelial neoplasm ② Skin Cancer ③ Malignant neoplasms other than above 1 , 2	Has the patient ever experienced any symptom of malignant neoplasm? Yes No	If yes, when was the first time the symptom of malignant neoplasm occurred? ／ ／ month day year
	State	① Primary ② Recurrent ③ Metastatic	（p） TNM　T　N　M	In case of colorectal cancer,the depth of tumor invasion M　SM or deeper
	Has the Patient been Informed of the Disease? Yes No	Name of Disease informed :（　　）		Informed of on ／ ／ month day year

11. In Case of Acute Myocardial Infarction	60 days after initial consultation,was the work done by the patient limited to the sedentary or light one?	Yes / No	12. In Case of Stroke	Do such objective,neurological sequelae as dysphasia,ataxia and paralysis still exist 60 days after the Initial consultation? Yes No If yes,please detail the sequelae.

13. Treatment Received as Outpatient

Treatment received in:	Please circle day(s) of ambulatory care or visit	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)

14. The ability to request — Can the patient understand the meaning of the act to claim insurance claims /benefits and receive it? Yes No Other (　　)

These statements are true and complete to the best my knowledge and belief.

Date: ______ ／ ______ ／ ______ month day year

Hospital's or Clinic's

Name ________________

Address ________________

Signature of attending physician ________________

Country ________________

Tel ________________

e-mail ________________

(*1) 1㎠ = 1 square centimeter (1 scm)

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