ATTENDING PHYSICAIAN'S STATEMENT（入院・手術・通院等証明書）

English Only; 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	/ / M D Y

2 (a) Name of Disease / Injury for Hospitalization (Operation)		ICD-10	Date of Diagnosis / / M D Y	Date of Onset / / M D Y — Physician's Opinion / Patient's Report
(b) Cause of the above(a)			/ / M D Y	/ / M D Y — Physician's Opinion / Patient's Report
(c) Complications			/ / M D Y	Period of Hospitalization (c): / / M D Y 〜 / / M D Y

3 Period of Medical Treatment	Date of / / M D Y	Final Consultation / Under Treatment	→ Date of Final Consultation / / M D Y
Period of Hospitalization	1st	from / / M D Y to 〜 / / M D Y	Inpatient / Discharged
	2nd	from / / M D Y to 〜 / / M D Y	Inpatient / Discharged
	If any other hospitalization, please fill in period of hospitalization.		

4 Previous Physician or Referring Physician	Yes / No	Name of Physician and Medical Institution	Period of Treatment from / / M D Y to 〜 / / M D Y

5 Description of the course of Disease/Injury since the initial consultation

(Please describe in detail)

6 In Case of Cervical Dysplasia	CIN : Ⅰ Ⅱ Ⅲ — by colposcopic examination or post-operative pathological examination etc..	Date of Diagnosis / / M D Y

7 In Case of Malignant Neoplasm and Intraepithelial Neoplasm

(a) Histopathological Examination	Yes / No		
(b) Initial Histopathological Examination	Date of Diagnosis	/ / M D Y	
	Diagnostic Name		
	TNM	T ( ) N ( ) M ( )	
	ICD-O	M - / ① ② ③ ⑥ ⑨	

(c) Examinations other than above

Examination	Date of Diagnosis	Diagnostics Result
Cytodiagnosis	/ / M D Y	
Endoscopy	/ / M D Y	
CT/MRI	/ / M D Y	
Ultrasound examination	/ / M D Y	
Others( )	/ / M D Y	

(d) Final Histopathological Examination	Date of Diagnosis	/ / M D Y	
	Diagnostic Name		
	TNM	T ( ) N ( ) M ( )	
	ICD-O	M - / ① ② ③ ⑥ ⑨	

(e) Type	① Intraepithelial neoplasm/Non-invasive carcinoma	② Invasive carcinoma/Others	③ Unknown		
(f) State	① Primary	② Recurrent	③ Metastatic	④ Others( )	
(g) In Case of Colorectal Cancer, the depth of tumor invasion	M	SM or deeper			
(h) Has the patient been informed of the disease?	Yes / No	Name of Disease informed:		Informed on / / M D Y	
(i) Has anyone in the family of the patient been informed of the disease?	Yes / No	Name of Disease informed:	Whom:	Informed on / / M D Y	

8 Please fill in all of the Operations that were performed on the Disease / Injury.			
1st	Surgical name	Date of Operations M / D / Y	Treatment site Left Right
	Type	① Craniotomy ② Trepanation ③ Thoracotomy/Thoracoscopic surgery ④ Laparotomy/Laparoscopic operation ⑤ Laser surgery ⑥ Fiberscopic surgery/Surgical Catheterization for limbs and others ⑦ Percutaneous operations ⑧ Transurethral operations ⑨ Transvaginal operations ◯ Others( )	
	Details	1. In case of Musculoskeletal	Open Surgery / Closed Surgery
		2. In case of Extremity, is operative site MP Joint or more proximal?	Yes / No
		3. In case of Epidermization or musculocutaneous flap, grafts or flaps cover	25cm or larger / smaller than 25cm
		4. In case of Oral surgery, have jaw bones been resected?	Yes / No
		5. Did the procedure require manipulation of Muscle or Bones?	Yes / No
		6. In case of Trepanation	Open new burr hole / Use existing burr hole
2nd	Surgical name	Date of Operations M / D / Y	Treatment site Left Right
	Type	① Craniotomy ② Trepanation ③ Thoracotomy/Thoracoscopic surgery ④ Laparotomy/Laparoscopic operation ⑤ Laser surgery ⑥ Fiberscopic surgery/Surgical Catheterization for limbs and others ⑦ Percutaneous operations ⑧ Transurethral operations ⑨ Transvaginal operations ◯ Others( )	
	Details	1. In case of Musculoskeletal	Open Surgery / Closed Surgery
		2. In case of Extremity, is operative site MP Joint or more proximal?	Yes / No
		3. In case of Epidermization or musculocutaneous flap, grafts or flaps cover	25㎠ or larger / smaller than 25㎠
		4. In case of Oral surgery, have jaw bones been resected?	Yes / No
		5. Did the procedure require manipulation of Muscle or Bones?	Yes / No
		6. In case of Trepanation	Open new burr hole / Use existing burr hole

9 Radiotherapy or Hyperthermia	Region	Period	from M / D / Y ~ to M / D / Y
	Stereotactic Irradiation / Small Sealed treatment / Hyperthermia / Others ( )	Total dose	Gy

10 Treatment Received as Outpatient	Please fill in Year and Month then circle Day(s) of treatment in 2(a) (Operation, Medication and Chemotherapy etc.).		
	M / Y	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)
	M / Y	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)
	M / Y	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)
11 The ability to claim	Can the patient understand the meaning of the action to claim (Death/Medical benefit) as well as to receive it?		Yes / No

12 Pre-existing condition and Chronic Disease	Existence / Non-existence — If Existence, please describe in detail as much as possible.	
	Name of Disease / Injury	Hospitalization Yes / No Treatment Received as Outpatient Yes / No Operations Yes / No
	Name of Physician and Medical Institution	Period of Medical treatment from M / D / Y ~ to M / D / Y

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

Hospital's or Clinic's

Name ______________________ Date M / D / Y

Address ______________________ Country ______________________

Tel ______________________ e-mail ______________________

Signature of attending physician ______________________