

# Patient Information

☆Please fill out in block letters

## I Patient Data (患者情報)

Date Contacted: (D/M/Y) / / NO.

### Contact Person (連絡窓口)

Name of the contact person (連絡窓口担当者名): \_\_\_\_\_  Male (男性)  Female (女性)

Relationship with the patient (患者との関係): \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

### Patient (患者)

Patient's Name (患者氏名) \_\_\_\_\_  Male (男性)  Female (女性)

Date of Birth DD/MM/YY (生年月日) \_\_\_\_\_ Age (年齢): \_\_\_\_\_

Nationality (国籍) \_\_\_\_\_ ★Please attach passport copy

Address (住所) \_\_\_\_\_

\_\_\_\_\_ Postal Code (郵便番号) \_\_\_\_\_

Tel (電話番号) \_\_\_\_\_ Mobile phone Number (携帯番号) \_\_\_\_\_

Patient's Occupation (患者の職業) \_\_\_\_\_ Name of Work Place (勤務先名称) \_\_\_\_\_

Native Language (母国語):  Japanese  English  Russian  Chinese  Other \_\_\_\_\_

Interpreter (通訳):  Required (要) → Desired language (希望言語): \_\_\_\_\_

Not required (不要)

Passport (パスポート):  Obtained (有) / パスポート番号 (Passport number) \_\_\_\_\_  Not obtained (無)

Visa Issuance Support (Visa の手配):  Needed (要)  Not Needed (不要)

Reason for seeking treatment in Japan (今回、日本の医療機関での治療を希望する理由):

Purpose of Request (Check all that apply) 依頼目的(複数回答可):

Examination (検査)  Treatment (治療)  Second opinion (セカンドオピニオン)  Other (その他) \_\_\_\_\_

Name of Requested Hospital and Department, Course of Examination and Treatment, etc.

(具体的に希望する医療機関、診療科、検査・治療内容)

Desired or Feasible Period for Treatment in Japan (日本で治療可能または希望する時期)

Desired Date of Arrival in Japan (来日希望日)

## Defrayer of our service fee and medical expenses(費用支出者)

Defrayer's name (費用支出者名) \_\_\_\_\_  Male (男性)  Female (女性)

Relationship with the patient (患者との関係): \_\_\_\_\_

Defrayer's Occupation (費用支出者の職業) \_\_\_\_\_  
(※If the Defrayer is the above patient, state 'same as above'.)

Name of Work Place (勤務先名称) \_\_\_\_\_  
(※If the Defrayer is the above patient, state 'same as above'.)

支払い限度額 (Spending Limit) \_\_\_\_\_

## II Treatment History and Progression (治療歴と経過)

※Please fill out by patient or family (患者様ご自身かご家族様をご記入ください。)

Diagnosis/診断名:

Inpatient (入院中)

Hospital Name (医療機関) \_\_\_\_\_

Department (診療科) \_\_\_\_\_

Treating doctor (担当医) \_\_\_\_\_

Home Resting (自宅療養中)

症状経過 (Progression of Illness): (病歴 History of illness: 日付 date、診断名 diagnosis、治療方法等 treatment, etc.)

Past Medical History(既往症):

Past Medical Treatment(既往症に対する治療):

ADL 日常生活動作 (Daily Activities): ※Check all that apply ✓

	Independent	Need Help	Dependent	Does not do
<b>Sitting(more than 2hrs)</b>				
<b>Walking</b>		<input type="checkbox"/> With assistance <input type="checkbox"/> With Crutches <input type="checkbox"/> Wheel Chair		
<b>Toileting</b>			<input type="checkbox"/> Diaper <input type="checkbox"/> Urinary catheter	
<b>Eating</b>				
<b>Remarks if any</b>				

Patient's Body Height: \_\_\_\_\_ cm Patient's Body Weight: \_\_\_\_\_ kg

★Please forward all the medical information such as medical report, examination Results, picture images by Email, postmail or fax.

### Ⅲ Companion Information(同行者情報)

#### Companion(同行者)

Yes(有)→Fill out the following Companion Information

No(無)

①Companion's Name (患者氏名) \_\_\_\_\_  Male (男性)  Female (女性)

Relationship with the patient(患者との関係): \_\_\_\_\_

Date of Birth DD/MM/YY (生年月日) \_\_\_\_\_ Age (年齢): \_\_\_\_\_

Nationality (国籍) \_\_\_\_\_ ★Please attach passport copy

Address (住所) \_\_\_\_\_

\_\_\_\_\_ Postal Code (郵便番号) \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Passport(パスポート):  Obtained (有) → Passport number (パスポート番号): \_\_\_\_\_  Not obtained (無)

Visa Issuance Support (Visaの手配):  Needed (要)  Not Needed (不要)

②Companion's Name (患者氏名) \_\_\_\_\_  Male (男性)  Female (女性)

Relationship with the patient(患者との関係): \_\_\_\_\_

Date of Birth DD/MM/YY (生年月日) \_\_\_\_\_ Age (年齢): \_\_\_\_\_

Nationality (国籍) \_\_\_\_\_ ★Please attach passport copy

Address (住所) \_\_\_\_\_

\_\_\_\_\_ Postal Code (郵便番号) \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Passport(パスポート):  Obtained (有) → Passport number (パスポート番号): \_\_\_\_\_  Not obtained (無)

Visa Issuance Support (Visaの手配):  Needed (要)  Not Needed (不要)

※Please fill out this request form in detail.

※When you send us this form, please attach passport copy as well.

(※できるだけ詳細に記入お願い致します。また弊社へ送信頂く際は、パスポートコピーの添付もお願い致します。)