

ATTENDING PHYSICIAN'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	<input type="radio"/> Male <input type="radio"/> Female	Date of Birth	/ / M D Y	
2 (a) Name of Disease / Injury for Hospitalization (Operation)		ICD-10	Date of Diagnosis	Date of Onset				
			/ / M D Y	/ / M D Y				
				<input type="checkbox"/> Physician's Opinion <input type="checkbox"/> Patient's Report				
(b) Cause of the above(a)			/ / M D Y	/ / M D Y				
(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	<input type="checkbox"/> Final Consultation <input type="checkbox"/> Under Treatment	→ Date of Final Consultation			/ / M D Y
	Period of Hospitalization	1st	from	/ / M D Y	to	/ / M D Y	<input type="checkbox"/> Inpatient <input type="checkbox"/> Discharged	
		2nd	from	/ / M D Y	to	/ / M D Y	<input type="checkbox"/> Inpatient <input type="checkbox"/> Discharged	
	If any other hospitalization, please fill in period of hospitalization.							
4 Previous Physician or Referring Physician	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Physician and Medical Institution			Period of Treatment from			to
								/ / ~ / / M D Y 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 : <input type="radio"/> I <input type="radio"/> II <input type="radio"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="radio"/> ① Intraepithelial neoplasm/Non-invasive carcinoma <input type="radio"/> ② Invasive carcinoma/Others <input type="radio"/> ③ Unknown							
(f) State	<input type="radio"/> ① Primary <input type="radio"/> ② Recurrent <input type="radio"/> ③ Metastatic <input type="radio"/> ④ Others(
(g) In Case of Colorectal Cancer, the depth of tumor invasion	<input type="checkbox"/> M <input type="checkbox"/> SM or deeper							
(h) Has the patient been informed of the disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Disease informed:			Informed on			/ / M D Y
(i) Has anyone in the family of the patient been informed of the disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Disease informed:		Whom:	Informed on			/ / M D Y
(j) Treatment Received as Outpatient	Please fill in Year and Month then circle Day(s) of treatment (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)	

