# ATTENDING PHYSICIAN'S STATEMENT

Please enter ☑ in the applicable sections

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|---|---|---|---|---|
| 1. Name | Chart No. ( ) | Male/Female ☐ ☐ | Date of birth | MM DD, YYYY |

| 2. Name of injury/disease | | Date of injury/illness | |
|---|---|---|---|
| A. Disease/injury that caused hospitalization (surgery), etc. | | MM DD, YYYY | ☐Doctor's assumption ☐Patient's declaration |
| B. Cause of A. | | MM DD, YYYY | ☐Doctor's assumption ☐Patient's declaration |

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|---|---|---|---|---|
| C. Any previous/ referring doctor for the above injury/illness? | Yes/No ☐ ☐ | Medical institution: | Date of initial visit to the previous/referring doctor MM DD, YYYY / ☐Unknown | |
| | A definitive diagnosis of malignant neoplasm given by the previous/referring doctor? | Yes/No ☐ ☐ | If Yes: | Test: ☐ Histopathological examination ☐Cytological examination ☐Others Diagnosis ( )Date of diagnosis____/____/____MM DD,YYYY |
| D. Background of initial visit | ☐Visited upon the patient's awareness of the symptom (around ____/____MM YYYY) ☐Visited upon findings via health checkup,etc. ☐Referred from previous doctor (around ____/____MM YYYY) ☐No chief complaint (visited for brief/thorough health checkup) ☐Others ( ) | | | |
| E. Complications treated during hospitalization ? | Yes/No ☐ ☐ | | Date of illness/injury: ____/____/____MM DD,YYYY | Is a hospitalization required exclusively for the complication? |
| | | | Treatment period: ____/____/____ MM DD, YYYY to ____/____/____ MM DD, YYYY | ☐Yes ☐No |

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| 3. Treatment period | Initial visit for A of 2:____/____/____MM DD,YYYY to ____/____/____MM DD,YYYY (Treatment: ☐Completed/☐Ongoing) |
| 4. Hospitalization period (incl. a day stay) | 1st:____/____/____MM DD, YYYY to____/____/____MM DD, YYYY (☐Discharged ☐Ongoing ☐To another hospital ☐To another Dept. ☐Death)<br>2nd:____/____/____MM DD, YYYY to____/____/____MM DD, YYYY (☐Discharged ☐Ongoing ☐To another hospital ☐To another Dept. ☐Death)<br>3rd and thereafter: |

**5. Current surgery performed**

| | | |
|---|---|---|
| A. Type of surgery | (1) Craniotomy (2) Trepanation (3) Thoracotomy (4) Thoracoscopy (5) Laparotomy (6) Laparoscopy (7) Fiberscopic or catheter surgery (8) Percutaneous (9) Transurethral (10) Transvaginal (11) Laser surgery (12) Others ( ) | |
| B. Contents of surgery | 1. If musculoskeletal surgery: Is it invasive? => a. Yes b. No | 2. If surgery of fingers/toes: Does it extend to the central system incl. MP joint? => c. Yes d. No |
| | 3. Does it involve muscle, tendon, or ligament treatment? => e. Yes f. No | 4. Area of skin graft (skin flap) => g. ≥25 $cm^2$ h. <25 $cm^2$ |
| | 5. If intraoral surgery: Is the jaw bone scraped? => i. Yes j. No | 6. If surgery of female reproductive organs: What organ was removed completely? => k. None l. Endometrium m. Left ovary n. Right ovary |

| Name of surgery *Surgery includes thoracic/abdominal drainage, stent replacement, and port placement. | Date of surgery | A. Type of surgery Select from (1) to (12) above. | B. Contents of surgery *Select all from among a. to n. above. |
|---|---|---|---|
| Left Right (Both) | MM DD, YYYY | | |
| Left Right (Both) | MM DD, YYYY | | |

For the 3rd and each subsequent surgery, if performed, specify also the surgery/procedure code, and the name, date, type, and details of the surgery.

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| 6. Radio/ Hyperthermia - therapy | Name of the radiation or Hyperthermia therapy | Site | | Period | (1) From:____/____/____ MM DD, YYYY to: ____/____/____ MM DD, YYYY<br>(2) From:____/____/____ MM DD, YYYY to: ____/____/____ MM DD, YYYY | Total dose | (1) Gy<br>(2) Gy |

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| 7. If acute myocardial infarction: Is a restriction on work beyond light or office labor still required in 60 days after the first visit? | ☐Yes ☐No |

| | | |
|---|---|---|
| 8. If stroke: Does the patient still have an objective neurological sequelae such as language disorder, ataxia, and paralysis in 60 days after the first visit? | Yes/No ☐ ☐ | Details of sequelae: |

**9. If Malignant/In situ neoplasm**

| Name of the tests performed until definitive diagnosis | Date of test | Summary of test results |
|---|---|---|
| Histopathological examination | MM DD, YYYY | |
| Others: _____ test | MM DD, YYYY | |

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|---|---|---|---|
| Date of definitive diagnosis | MM DD, YYYY | Type of cancer | ☐Carcinoma in situ or non-invasive cancer ☐Other cancer |
| (p) TNM classification | T( ) N( ) M( ) | Depth of invasion of colorectal cancer | ☐M ☐SM or beyond |
| Classification of this malignant neoplasm | ☐Primary ☐Recurrent ☐Metastatic | If cervical cancer: | ☐CIN2 ☐CIN3 ☐CIS ☐Others |

| | | |
|---|---|---|
| Any history of malignant/in situ neoplasm? | ☐Yes Name of disease: | Date of diagnosis: Around_____ |
| Disclosed? | ☐Yes, the diagnosis of _____(disease name)was disclosed to the patient around___/___/____MM DD, YYYY ☐No | |

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| 10. Mental capacity: Do you think the patient has mental capacity to express his/her will? | ☐No |

I hereby certify the above (diagnosis). ____/____/____ MM DD, YYYY

Address:
Name of the hospital or clinic and Dept:
Name of doctor:

Note: Any and all corrections must be identified with signate.