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Application for medical coordination in Japan

READ THE TERMS AND CONDITIONS OF THE APPLICATION FOR MEDICAL COORDINATION AND SIGN

- □ Applicant's name _____
- □ Filled out from the words of the Patient (by whom) _____
- □ The purpose of this service is to create a comfortable environment for patients, as well as to resolve language and cultural problems that may arise during examination or treatment in Japan. The service may include a request for remote medical consultation, interpreting service during examination/treatment, visa support, translation of medical information, and providing travel services if necessary.
- □ This service does not guarantee that treatment will be provided or that it will be effective. The tour operator does not bear any responsibility for medical errors committed by the medical institution. The decision to visit Japan or apply for a remote consultation is made by the patient himself entirely his responsibility.
- □ A prerequisite for the provision of this service will be the correct information, provided by the patient. If the information provided is not correct, there is a possibility of difficulties in determining the course of treatment, as well as the need to use types of treatment and procedures not originally intended.
- □ New diseases or symptoms discovered as a result of examinations and treatment after arrival in Japan may incur additional costs. In the event of patient insolvency, our company reserves the right to terminate services.
- □ The occurrence of natural disasters, military operations, and other force majeure circumstances may lead to termination or partial reduction of services.
- □ Depending on the circumstances of the receiving medical institution, the state of communications and transport, the workload of the Tour Operator, and the inability to provide an interpreter, the provision of this service may be delayed for some time, or it may be refused.
- □ The service for selecting a medical institution (fee for coordination of medical care) is paid before the start of the service.
- □ The fee for care coordination is not dependent on the outcome of the coordination. Refunds for the work done by the coordinator to translate medical material to find a medical facility, coordinate an appointment, and other work on the application are not made.

Applicant's signature _____ Application date _____

Required fields are highlighted in green

Patient details /間者情報

Patient's name/患者氏名_____□ 男 Male □ 女 Female Citizenship/国籍_____Date of birth/生年月日_____г年 м月 д日_

Height/身長_____Weight/体重_____

Address /住所 _____

郵便番号/Post code 電話番号／tel

傷病名/***Diagnosis***

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傷病名（現在、患っている病気や怪我）/Diagnosis, symptoms	Currently: □ did not go to a medical institution □ monitoring the dynamics □ outpatient treatment /通院 □ inpatient treatment /入院中 name of the hospital/医療機関: _____ department/診療科:_____

MEDICAL HISTORY **/症状経過**

(a step-by-step description of the development of the disease, including dates, examination methods, diagnosis, treatment received, list and dosage of medications, current condition, etc.)

If you have an epicrisis (extract from the medical history), please attach it.

Example:

June 2014, diabetes mellitus was diagnosed in such and such a hospital. No medications or treatment are prescribed.

On May 7, 2015, as a result of an examination, a diagnosis of stage 2 stomach cancer was made.

May 9, 2015 – hospital, May 11 – surgery

July 2, 2015 – discharge. After 2 months, return to the doctor for an endoscopy.

I am not currently being examined.

November 30, 2017 – sharp chest pain, I decided to get examined in Japan.

List of medications taken**/現在服中の薬**

List the name and amount of medications currently taken, if any.

Do you have any allergies?	□ no □ yes □ I don't know

If you answered "yes" to the previous question, please indicate what you are allergic to.
(eg, contrast agent, anesthesia, food, etc.) _____

Do you smoke?	□ no □ yes (____ pieces per day / since _____ years) □ gave up (at ____ years)

Level of activity in daily life/日常生活動作

Walking/**移動** □ Independently/**自立** □ With the help/**介助**

Nutrition/**食事** □ On your own/**自立** □ With help/**介助**

Toilet/**排泄** □ On your own/**自立** □ Dipers/catheter/**オムツ／カテーテル**

Other notes:

The special type of transportation (stretcher, wheelchair, is accompanying medical personnel needed)/**搬送モード（ｽﾄﾚｯﾁｬｰ、車椅子、医療者のｱﾃﾝﾄﾞ等の必要）**

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□ Necessary (indicate which one)/ 要 □ Unnecessary/不要

_____

Other problems and need for consultations in connection with air travel/
その他。飛行機旅行に関連した相談などの必要性

Reason for wanting to get treatment/examination in Japan/
今回、日本の医療機関での治療を希望する理由

For example, doubt about the results of diagnosis and treatment methods received in other countries, etc.

Purpose of the request/依頼目的 ***(you can select multiple answers)/***（複数回答可）

- ☐ Correspondence consultation／遠隔相談
- ☐ Examination/検査
- ☐ Treatment/治療
- ☐ Second opinion/セカンドオピニオン
- ☐ Other/その他

Specific hospital, department, examination, treatment (if any)/ 具体的に希望する医療機関、診療科、検査・治療内容_____

Desired date of examination, treatment in Japan /検査などの希望日
indicate the dates of your request in order of priority

1st wish year 年 month 月 day 日
2nd wish year 年 month 月 day 日
3rd wish year 年 month 月 day 日

Period of planned stay in Japan /滞在可能な期間または希望する滞在期間

Accompanying / 帯同者

- ☐ Yes/あり
- ☐ No/なし

If there is/「あり」の場合

- ☐ Family member/家族（father, mother, brother, sister)/（父・母・兄・弟・姉・妹）
- ☐ Relative/親戚
- ☐ Others/その他

Urgent contact in Japan and at home / 緊急連絡先（現地と日本）

In Japan／日本 Full name/氏名_____(Relation to patient/続柄:) □男M □女F

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Address／住所: Tel／電話:
At home／母国 Full name/氏名_____(Relation to patient/続柄:　　) □男M　□女F Address／住所: Tel／電話:
***Attached medical information*/入手可能な医療情報等（入手済であれば添付をお願いします）**
☐ Medical information/医療情報 (extract from medical history) ☐ Graphic images（CT / MRI / X-ray, ultrasound）/画像 (CT, MRI, x-ray, エコ) ☐ Copy of the passport ☐ Other／その他