診 療 情 報 提 供 書

紹介先医療機関名　厚生連 糸魚川総合病院

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| 担当医 | 放射線科 | 外来担当医 | 先生 | |  | 令和 | |  | 年 |  | 月 |  | 日 | |
| 紹介元医療機関名称 | | |  | | | | | | | | |
| および所在地 | | |  | | | | | | | | |
| 医師氏名 | | |  | | | | | | | 印 | |
| 電話番号 | | |  | | | | | | | | |

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| フリガナ |  | | | | | 性 別 | | |
| 患者氏名 |  | | | | 様 | 男 ・ 女 | | |
| 生年月日 | 大・昭・平・令 | 年 | 月 | 日 | 生　（ |  | ）歳 |  |
| 患者住所 |  | | | | 連絡先 |  | | |

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| 傷病名 | |  | | | | |
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| 紹介目的・依頼検査種別・検査部位 | | |  | | | |
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| 既往歴・症状経過・検査結果・治療経過・現在の処方 等 | | | | Cr値もしくはeGFR値  (造影検査の方のみ) |  | |
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本用紙は複写いただき、原本を期日までに糸魚川総合病院地域医療連携室までお届けください．