支部様式第４号　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　（Ａ）

せ き 柱 の 傷 病 調 書

医 療 機 関 の 長　様

地方公務員災害補償基金千葉県支部長

　　　　医学的意見の照会について（依頼）

下記の職員の公務（通勤）災害の補償を行うに当たり、医学的意見が必要ですので、本書のＢ面にせき柱の傷病について意見等を記入くださるようお願いします。

なお、意見書料の請求は、診療費請求書に文書料・室料差額証明書を添付して、請求してください。

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| 被災職員 | 災害発生年月日 | | | | | | | | |  | | | | | | | |  | | | | | 年 | | | |  | | | 月 | | | | |  | | | | 日 | | | | | 所属 | | | | | | |  | | | | | | | | | | | | | |
| 氏名 | |  | | | | | | | | | | | | | | | | | | | | | | 生年月日 | | | | | | | |  | | | | | | | | 年 | | | | |  | | | | 月 | |  | | | 日 | | | 職名 | | |  | | | |
| 身長 | |  | | | ・ | | | | |  | | | | | | | | | | ㎝　　体重 | | | | | | | | | | | |  | | | | | ・ | | | | |  | | | | | | | ㎏ | | | |  | | | |  | | | | | | |
| 災 害 発 生 の 状 況 | （概要） | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| （その際の姿勢） | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| の負担腰部等 | | 取り扱った物 | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 材質 | | |  | | | | |
| 重量 | | | |  | | | | | ・ | | |  | | | | | | | ㎏ | | | | 形状 | | | | | 縦 | | | | | |  | | | | | | | | | | ㎝・横 | | | | | |  | | | | | | ㎝・高 | | |  | ㎝ | |
| 療 養 状 況 | 診断名 | | | | （せき柱の傷病について記載してください。） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 医療機関名 | | | | | | | | |  | | | | | | |
| 療養期間 | | | |  | | |  | 年 | | | |  | | | 月 | | | |  | | | 日～ | | | | |  | | | | 年 | |  | | 月 | | | |  | | 日 | | | 入院･通院の別 | | | | | | | | | | | 入院  通院・(休業中　就業) | | | | | | | | |
| 継続中・治ゆ・中止 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 既 往 症 歴 | 診　断　名 | | | | | | | | | | | | | 療　養　期　間 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 医　療　機　関　名 | | | | | | | | | | | | | | | | | | | |
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| 上記のとおり相違ありません。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 被災職員氏名 | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  |
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（注）本書は、せき柱のうち（頸椎・胸椎・腰椎）のけが又は病気の場合に、Ａ面に必要事項を記載し初診日又は翌日に「診療費請求書」及び「文書料・室料差額証明書」を添付して指定医療機関に提出すること。

（Ｂ）

医　学　的　意　見　書

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 氏名 | | | |  | | | | | | | | | | | | | | | 傷病名 | （せき柱の傷病について記入してください。） | |
| 初診日 | | | |  | | | 年 | | | |  | | | 月 | |  | | 日 |  | |
| 初診時の所見 | | (主訴) | | | | | | | | | | | | | | | | | | | |
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| (他覚的所見) | | | | | | | | | | | | | | | | | | | |
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| レントゲンＭＲＩ等の画像所見 | | (災害に関係があると考えられる所見) | | | | | | | | | | | | | | | | | | | |
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| (災害に関係がない（以前から存在した）と考えられる所見) | | | | | | | | | | | | | | | | | | | |
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| その他の  検査所見 | |  | | | | | | | | | | | | | | | | | | | |
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| 本件傷病の有力な発症原因 | | （（Ａ）に記載の「災害発生の状況」との因果関係） | | | | | | | | | | | | | | | | | | | |
| □　有力な発症原因である　　□　有力な発症原因でない（以下にその理由を記載ください。） | | | | | | | | | | | | | | | | | | | |
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| 素因や既往症歴について | | (素因や既往症の有無) | | | | | | | | | | | | | | | | | | | |
| □　あり　　□　なし | | | | | | | | | | | | | | | | | | | |
| (ありの場合上記傷病と素因・既往病歴との因果関係について御教示ください。) | | | | | | | | | | | | | | | | | | | |
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| (療養状況及び症状の経過) | | | | | | | | | | | |  | | | | | | | | | |
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| 本件傷病の急性症状の消退見込時期(または消退した時期) | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | 年 |  | | 月 |  | | | | 日ごろ | | | | | | | | |
|  | 本書のとおり意見を述べます。 | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | |  | | | 年 | | |  | | 月 | |  | 日 | | | |
|  | 医療機関名 | | | | | | | | | | | | | | | | | | | |  |
|  | 医　師　名 | | | | | | | | | | | | | | | | | | | |  |