Osaka University Hospital

Second Opinion Outpatient Application Form (Medical Institution use)

Patient Support Center FAX 06-6879-5390 TEL 06-6879-5090

Name of Medical Institution			Application Date Dept.	DD/MM/Y	YYY	
Ā	ddress					
D	octor in Charge					
Т	EL	Rep.		FAX		
[Patient]	Data]					
	(Furigana)		Date of D	DD/MM/YYYY		М
Name			Birth		(Age)	F
			TEL			
Specific content o consultatio	f					
Desired			Desired			
Dept.	*See list of clinical dep	*See list of clinical depts. below.				
Has the pa		saka University Hospital?	2	Yes 🗆 No		
If "Yes," please fill in the patient registration card no. if known						
С	ircle Materials (X-ray, CI	Г, MR, Endoscope, Ultrasou	und, Electr	ocardiogram, Examination	Records, etc.)	
Other	Inconvenient Days	onvenient Days Please check with the patient and select from all below. □ 1 hour 33,000 yen □ Not for litigation purposes □ Consultation for individual or family □ Only provide opinion, not examination □ Consent Form (proxy) brought on day		family		

*Clinical Dept.

Department of Medicine	Hematology & Oncology	Pediatric Surgery	Obstetrics & Gynecology Pediatrics	
Department of Wedlenie	Geriatrics & Hypertension	Ophthalmology		
Gastroenterology and	Kampo Medicine	Otorhinolaryngology-Head	Urology	
Hepatology	and Neck Surgery		Diagnostic and	
Metabolic Medicine		Orthopaedic Surgery	Interventional Radiology	
Respiratory Medicine	Department of Surgery	Dermatology	Radiotherapy	
Clinical Immunology	Gastroenterological Surgery	Plastic Surgery		
Cardiovascular Medicine	Cardiovascular Surgery	Neurosurgery		
Nephrology	Breast and Endocrine Surgery	Anesthesiology		
Neurology and Cerebrovascular	General Thoracic Surgery			
Diseases				

(1)

Letter of Referral (Medical Information Provision Form)

(Referring Medical Institution Format also acceptable)

Second Opinion Outpatient Cli	inic	DD/MM/YYYY
Dept.	Referring MedicalInstitution Name &Address	
Dr.	TEL (Contact)	
DI.	Dept.	
	Doctor in Charge	

Osaka University Hospital

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Name and Gender of Patient	Mr./Mrs.	(M, F)
Date of Birth (Age)	DD/MM/YYYY (Age)
Name of Disease	1. 2. 3.	
Stage, Classification of Severity etc.		
History of Present Illness (Please write in free form. If you run out of space, please attach a separate sheet.)		
Current Treatments and Prescriptions		
Future Treatment Plans		



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Consultation Consent Form

Attn: Director, Osaka University Hospital

I hereby apply with the attached Application Form for an outpatient second opinion from your hospital and agree to the following items.

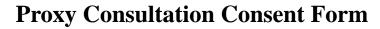
1. Matters stated in the "Second Opinion Outpatient Information"

2. Not to use for litigation purposes

3. Pay the amount specified as optional medical treatment fees

DD/MM/YYYY

Patient's Name	(Seal)
Attendee Name	
(Relationship with Patient)
Attendee Name	
(Relationship with Patient)
Attendee Name	
(Relationship with Patient)



DD/MM/YYYY

Attn: Director, Osaka University Hospital

Name of Patient (Furigana): _____ (Seal)

Address: _____

TEL: _____ (____)

I hereby apply with the attached Application Form for an outpatient second opinion from your hospital and agree to the following items.

1. Matters stated in the "Second Opinion Outpatient Information"

- 2. Not to use for litigation purposes
- 3. Pay the amount specified as optional medical treatment fees

In addition, I agree to the following persons bringing the letter of referral and materials from my doctor regarding my medical condition to seek a second opinion from a doctor at Osaka University Hospital.

Proxy

Name	Relationship with Patient	Contact Info. (TEL/FAX etc.)

*Note 1: Please have this filled in by the patient themselves. If it is difficult for them to do so, it can be filled in by a proxy.

*Note 2: The person receiving the consultation should bring personal identification (health insurance card, driver's license etc.)