Osaka University Hospital ①

Second Opinion Outpatient Application Form (Medical Institution use)

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

Application Date DD/MM/YYYY

Name of Medical Institution _____ Dept. _____

Address _____

Doctor in Charge _____

TEL _____ Rep. _____ FAX _____

[Patient Data]

Name	(Furigana)	Date of Birth	DD/MM/YYYY (Age)	M F
		TEL		
Specific content of consultation				
Desired Dept.	*See list of clinical depts. below.	Desired Doctor		
Has the patient previously visited Osaka University Hospital? ☐ Yes ☐ No If "Yes," please fill in the patient registration card no. if known ☐☐☐ - ☐☐☐☐ - ☐				
Circle Materials (X-ray, CT, MR, Endoscope, Ultrasound, Electrocardiogram, Examination Records, etc.)				
Other	Inconvenient Days	Please check with the patient and select from all below. ☐ 1 hour 37,950 yen ☐ Not for litigation purposes ☐ Consultation for individual or family ☐ Only provide opinion, not examination ☐ Consent Form (proxy) brought on day		

***Clinical Dept.**

Department of Medicine

Gastroenterology and Hepatology
Metabolic Medicine
Respiratory Medicine
Clinical Immunology
Cardiovascular Medicine
Nephrology
Neurology and Cerebrovascular Diseases
Hematology & Oncology
Geriatrics & Hypertension
Kampo Medicine

Department of Surgery

Gastroenterological Surgery
Cardiovascular Surgery
Breast and Endocrine Surgery
General Thoracic Surgery
Pediatric Surgery
Ophthalmology
Otorhinolaryngology-Head and Neck Surgery
Orthopaedic Surgery
Dermatology
Plastic Surgery
Neurosurgery
Anesthesiology
Obstetrics & Gynecology
Pediatrics
Urology
Diagnostic and Interventional Radiology
Radiotherapy
Psychiatry

②

Letter of Referral (Medical Information Provision Form)

(Referring Medical Institution Format also acceptable)

Osaka University Hospital

Second Opinion Outpatient Clinic

DD/MM/YYYY

_____ Dept.

Dr. _____

Referring Medical Institution Name & Address	
TEL (Contact)	
Dept.	
Doctor in Charge	

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	

③

(If Patient can Visit)

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_____**)**

④

Proxy Consultation Consent Form

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.)**