第3号様式4

尼崎市妊産婦健診受診結果報告書（償還払い＜多胎妊婦＞用・国外版）

Prenatal checkup report

妊産婦氏名　Name（＿＿＿＿＿＿＿＿＿＿＿＿＿＿）

生年月日　Date of birth（　　　）year（　　　）month(　　　)day

Please check the appropriate box and enter the cost of the medical checkup（Not covered by insurance only）

実施内容

	Date Month/Date/Year number of weeks of pregnancy	Health Examination Items	Out-of-pocket Fee
Less than 22 weeks gestation	/ / number of weeks of pregnancy	☐medicai examination ☐Prenatal Ultrasound Examination ☐Urine ☐Blood Test ☐Chlamydia Tracho ☐cervical cancer screening	
After 22 weeks of pregnancy	/ / number of weeks of pregnancy	□medicai examination □Prenatal Ultrasound Examination □Urine ☐Blood Test ☐Bacteriological Examination	
	/ / number of weeks of pregnancy	□medicai examination □Prenatal Ultrasound Examination □Urine ☐Blood Test	
Throughout Pregnancy	/ /	□medicai examination □Prenatal Ultrasound Examination □Urine	
	/ /	□medicai examination □Prenatal Ultrasound Examination □Urine	
	/ /	□medicai examination □Prenatal Ultrasound Examination □Urine	
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	/ /	□medicai examination □Prenatal Ultrasound Examination □Urine	
mother's check up (less than 4 weeks postpartum)	/ / Month Date Year	☐medicai examination ☐Urine ☐Edinburgh Postnatal Depression Scale(Attachment required)	
mother's check up (within 4-8 weeks postpartum)	/ / Month Date Year	☐medicai examination ☐Urine ☐Edinburgh Postnatal Depression Scale(Attachment required)	

上記のとおり、健康診査を実施しました。　I certify that these checkups above were done.

実施機関名　Name of healthcare provider ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

担当医師または助産師名　Name of Physician or Midwife ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

＊複数の医療機関の受診がある場合は、**機関別**に報告書を記載してください。