第3号様式2

尼崎市妊婦健診受診結果報告書（償還払い用・国外版）

Gynecological checkup report

受付印

妊婦氏名　Name of the expectant mother ______________________

生年月日　Date of birth　Month ／ Day ／ Year

健診実施日、妊娠週数、実施健診項目にレ点を、また実施健診項目に要した費用をご記入ください。
Fill in following form relating gynecological checkups after date of the examination that you examined for the expectant mother.
(Please print legibly or type.)

実施内容

	Date / Weeks of pregnancy	助成対象健診項目	Out-of-pocket Free
Before 22 Weeks of Pregnancy	/ / Month Date Year Weeks of pregnancy	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine ☐Blood Test ☐Chlamydia Tracho ☐carcinoma of uterine cervix Cytodiagnosis	
In 22 Weeks of Pregnancy or later	/ / Month Date Year Weeks of pregnancy	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine ☐Blood Test ☐Bacteriological Examination	
	/ / Month Date Year Weeks of pregnancy	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine ☐Blood Test	
Throughout Pregnancy	/ / Month Date Year	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine	
	/ / Month Date Year	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine	
	/ / Month Date Year	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine	
	/ / Month Date Year	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine	
	/ / Month Date Year	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine	
	/ / Month Date Year	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine	
	/ / Month Date Year	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine	
	/ / Month Date Year	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine	
	/ / Month Date Year	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine	
	/ / Month Date Year	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine	
	/ / Month Date Year	☐Physical Examination ☐Prenatal Ultrasound Examination ☐Urine	

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。