様式第3号（2）

尼崎市妊産婦健診受診結果報告書（償還払い用・国外版）

Prenatal checkup report

受付印

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 / number of weeks of pregnancy	Health Examination Items	Out-of-pocket Fee
Less than 22 weeks gestation	/ / Month Date Year number of weeks of pregnancy	☐medical examination ☐Prenatal Ultrasound Examination ☐Urine ☐Blood Test ☐Chlamydia Tracho ☐cervical cancer screening	
After 22 weeks of pregnancy	/ / Month Date Year number of weeks of pregnancy	□medicai examination □Prenatal Ultrasound Examination □Urine □Blood Test □Bacteriological Examination	
	/ / Month Date Year number of weeks of pregnancy	□medicai examination □Prenatal Ultrasound Examination □Urine □Blood Test	
Throughout Pregnancy	/ / Month Date Year	□medicai examination □Prenatal Ultrasound Examination □Urine	
	/ / Month Date Year	□medicai examination □Prenatal Ultrasound Examination □Urine	
	/ / Month Date Year	□medicai examination □Prenatal Ultrasound Examination □Urine	
	/ / Month Date Year	□medicai examination □Prenatal Ultrasound Examination □Urine	
	/ / Month Date Year	□medicai examination □Prenatal Ultrasound Examination □Urine	
	/ / Month Date Year	□medicai examination □Prenatal Ultrasound Examination □Urine	
	/ / Month Date Year	□medicai examination □Prenatal Ultrasound Examination □Urine	
	/ / Month Date Year	□medicai examination □Prenatal Ultrasound Examination □Urine	
	/ / Month Date Year	□medicai examination □Prenatal Ultrasound Examination □Urine	
	/ / Month Date Year	□medicai examination □Prenatal Ultrasound Examination □Urine	
	/ / Month Date Year	□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。