様式2号-2(1)

自立支援医療(更生医療)要否意見書 聴覚障害用

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| --- |
| 1 新規　2 変更　3 再認定 |
| ふりがな  氏　　名 | |  | | 生年月日 | 年　　月　　日 | |
| 住　　所 | |  | | | | |
| 障害 | 原　病　名： | | | | | |
| 機能障害名： | | | | | |
| 障害の発生と経過 | (1)上記の機能障害を起こした年月日　　　　　　　 　　年　　　月　　　日 | | | | | |
| (2)障害が永続すると判定された日　　　　　　 　　　　年　　　月　　　日　推定・確認 | | | | | |
| (3)現在までの治療経過 | | | | | |
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| 手術年月日 | | | 年　　 月 　　日 | | | |
| 医療の具体的方針 | | |  | | | |
| 治療効果の見込み | | | 術前の等級　　　級  術後の等級　　　級 | | | |
| 身体の状況及び所見  音声，構音障害及びその他の機能障害（形態異常）の所見  過去の手術歴及び今回の手術内容  picture2 | | | | | | |

様式2号-2(2)

オージオメーター型式

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オージオメーター型式

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| |  | | --- | | 伝音性難聴 | | 感音性難聴 | | 混合性難聴 |  |  | | --- | | 右　　　　. 　　dB | | 左　　　　. 　　dB |   １ 聴覚障害の状態及び所見  　(1)　聴力（会話音域の平均聴力レベル）  　(2)　障害の種類  　(3)　鼓膜の状態  右　　　　　　　　　左  オージオメーター型式   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |   250 500 1000 2000 4000Hz  0  5  10  15  20  25  30  35  40  45  50  55  60  65  70  75  80  85  90  95  100  105  dB  ２　補聴器及び術後の聴力検査   |  | | --- | | 右　　　　. 　　dB | | 左　　　　. 　　dB |  |  | | --- | | 右　　　　. 　　dB | | 左　　　　. 　　dB |   ３　語音による検査  　　　語音明瞭度（検査データーを添付）   |  | | --- | | 右　　　　％（ dB） | | 左　　　　％（ dB） |  |  | | --- | | 右　　　　％（ 　　dB） | | 左　　　　％（ 　　dB） | |

様式2号-2(3)

自立支援医療(更生医療)費概算額算出表 聴覚障害用

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| 氏　　名 | |  | | | | | 年　齢 | | | 歳 | |
| 手 術 名 | |  | | | | | | | | | |
| 診療見込  期　間 | | 入 院 | 自　 　月　 　日 | | 入院外 | | | | 自　　　月　　　日 | | |
| 至　 　月 　 日 | | 至　　　月　　　日 | | |
| 手　　　術　　　料 | 内　　　　　　容 | | | 第１月 | | 第２月 | | 第３月 | | | 合　計 |
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| 輸血・麻酔 | | |  | |  | |  | | |  |
| 薬剤・材料等 | | |  | |  | |  | | |  |
| 投  薬 | 院外処方（ 有・無 ） | | |  | |  | |  | | |  |
| 薬品料 | | |  | |  | |  | | |  |
| 薬品名： | | |  | |  | |  | | |  |
| 注  射 | 注射料 | | |  | |  | |  | | |  |
| 注射名： | | |  | |  | |  | | |  |
| 処  置 | 術後処理等（処置時の薬剤等を含む） | | |  | |  | |  | | |  |
|  | | |  | |  | |  | | |  |
| 検　査 | Ｘ-Ｐ・ＣＴ等 | | |  | |  | |  | | |  |
| 血液検査等 | | |  | |  | |  | | |  |
| 基本診療（初診・再診料） | | | |  | |  | |  | | |  |
| 入 院 料 | | | |  | |  | |  | | |  |
| そ の 他： | | | |  | |  | |  | | |  |
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| 合　　計 | | | |  | |  | |  | | | 円 |

上記のとおり診断しました。　　　　　　　　年　　　月　　　日

指定自立支援医療機関（更生医療）所在地

　　　　　　　　　　　　　　　　名　称

指定医師氏名