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| 検査依頼用紙（診療情報提供書） | | | | | | | | | | | | | | | | | | | |  | | | | | |
| 社会福祉法人あそか会 | | | | | あそか病院　放射線科 | | | |  | | |  | | 紹介元医療機関名 および 所在地 | | | | | | | | | | | |
| 〒135-0002 | | | 東京都江東区住吉-1-18-1 | | | | | | | | |  | |  | | | | | | | | | | | |
| 電話 | | 03-3632-0290　(代表) | | | | | | | | | | | |
| 03-3632-0293　(放射線科直通) | | | | | | | | | |  | |
| Fax | | 03-3632-4276 | | | | | | | | | |  | | 医師名 | | | | | | | | | | | |
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| 氏  名 | フリガナ | | | | | | | | | 性  別 | |  | | | 生年  月日 | |  | 年 | | | 月 | | 日 | | |
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| 検査依頼内容　　　該当する部分にチェックをお願いいたします | | | | | | | | | | | | | | | | | | | | | | | | | |
| 区  分 |  | | | | |  | | | | | | | | | | 造 |  | | | | | | | |  |
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| 依  頼  内  容 |  | | |  | | | |  | | |  | | | | | |  | |  | | | | | | |
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| 以下の検査項目は左右を選択してください。 | | | | | | | | | | | | | | | | | | | | | | | | |
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あそか病院ID（　　　　　　　　　　）※検査時に放射線科で記入します。