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| **在宅人工呼吸器使用患者支援事業　実績報告書**  様式第２号（第８条第２項関係） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **（ 　　　年 　月分）** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ふりがな  氏名 | | | |  | | | | | | | | | | | | | 性別 | | | | | 男 ・ 女 | | | | | 生年月日 | | | | 年　　　月　　　日 | | | | | | | | | | | |
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| 住所 | | | | 〒　　－ | | | | | | | | | | | | | | | | | | | 出生  都道府県 | | | |  | | | | | | | | 発症時の職業 | | |  | | | | |
| TEL ( ) | | | | | | | | | | | | | | | | | | |
| 発症年月 | | | | 年　　　月 | | | | | | | | 初診年月日 | | | | | | 年　　月　　日 | | | | | | | | | | | 保険種別 | | | 協・組・共・国・介・他（　　　） | | | | | | | | | | |
| 指定難病名 | | | |  | | | | | | | | | | | | | | | | | | | 医療受給者証  受給者番号 | | | | | | | | | |  | | | | | | | | | |
| 当 月 の 訪 問 看 護 状 況 | | 診療報酬対象　訪問看護 | | | | | | | 回数 | | | | | | （月　　　　　　回、週平均　　　　　　回） | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 時間 | | | | | | （月間総　　　　時間、１回平均　　　時間） | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 訪問看護の内容 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療報酬対象　外訪問看護 | | | | | | | 回数 | | | | | | （月　　　　　　回、週平均　　　　　　回） | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 時間 | | | | | | （月間総　　　　時間、１回平均　　　時間） | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 訪問看護の内容 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 上記患者に対し在宅人工呼吸器使用患者支援事業に基づく訪問看護を行ったので、その実績を報告します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|
| 熊本市長　　様 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 年　　　月　　　日 | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | 法人（団体）所在地 | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | 法人（団体）名称 | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | 代表者職氏名 | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | ㊞ | | |
| 訪問看護ステーション等医療機関 所在地 | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| 名称 | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | 管理者氏名 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | 電話番号 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| **在宅人工呼吸器使用患者支援事業**  様式第３号（第８条第２項関係） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **訪問看護実績報告内訳書　（　　　　　　年　　　月分）** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 対象患者氏名 | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
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| 診療報酬  の区分 | | 日  回数 | | １ | | | ２ | | | ３ | | | ４ | | ５ | | | ６ | | ７ | | | ８ | | ９ | | 10 | | 11 | | | | 12 | | 13 | 14 | | 15 | | 16 |
| 診療報酬対象 | | １回目 | |  | | |  | | |  | | |  | |  | | |  | |  | | |  | |  | |  | |  | | | |  | |  |  | |  | |  |
| ２回目 | |  | | |  | | |  | | |  | |  | | |  | |  | | |  | |  | |  | |  | | | |  | |  |  | |  | |  |
| ３回目 | |  | | |  | | |  | | |  | |  | | |  | |  | | |  | |  | |  | |  | | | |  | |  |  | |  | |  |
| 診療報酬対象外 | | ４回目 | |  | | |  | | |  | | |  | |  | | |  | |  | | |  | |  | |  | |  | | | |  | |  |  | |  | |  |
| ５回目 | |  | | |  | | |  | | |  | |  | | |  | |  | | |  | |  | |  | |  | | | |  | |  |  | |  | |  |
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| 診療報酬  の区分 | | 日  回数 | | 17 | | | 18 | | | 19 | | | 20 | | 21 | | | 22 | | 23 | | | 24 | | 25 | | 26 | | 27 | | | | 28 | | 29 | 30 | | 31 | | 計 |
| 診療報酬対象 | | １回目 | |  | | |  | | |  | | |  | |  | | |  | |  | | |  | |  | |  | |  | | | |  | |  |  | |  | |  |
| ２回目 | |  | | |  | | |  | | |  | |  | | |  | |  | | |  | |  | |  | |  | | | |  | |  |  | |  | |  |
| ３回目 | |  | | |  | | |  | | |  | |  | | |  | |  | | |  | |  | |  | |  | | | |  | |  |  | |  | |  |
| 診療報酬対象外 | | ４回目 | |  | | |  | | |  | | |  | |  | | |  | |  | | |  | |  | |  | |  | | | |  | |  |  | |  | |  |
| ５回目 | |  | | |  | | |  | | |  | |  | | |  | |  | | |  | |  | |  | |  | | | |  | |  |  | |  | |  |
| * **記入方法：訪問された日の欄に看護者の職種を下記の分類（正・准）で御記入ください。** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **正：訪問看護を実施したのが、保健師、助産師、看護師、理学療法士、作業療法士、言語聴覚士のいずれかの職種の場合** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **准：訪問看護を実施したのが、准看護師の場合** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 上記のとおり相違ないことを証明します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 法人（団体）所在地 | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 法人（団体）名称 | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 代表者職氏名 | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | ㊞ | | | | | | |

様式第５号（第９条関係）

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| **在宅人工呼吸器使用患者支援事業** | | | | | | | | | | | | | | | | | | | |
| **訪問看護費用請求書（　　　　　　年　　　月分）** | | | | | | | | | | | | | | | | | | | |
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| 請求金額 | 円 | | | | | |  | | | | | | | | | | | | |
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| 請求内訳 | |  | | | | | | | | | | | | | | | | | |
| 対象患者氏名 | | 区分 | | | 単価 | | | 回数 | | | | | 金額 | | | | | | |
|  | | 診療報酬対象 | | |  | | |  | | | | |  | | | | | | |
| 診療報酬対象外 | | |
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| 診療報酬対象外 | | |
| 上記のとおり請求します。なお、支払金額は下記の口座に振り込んでください。 | | | | | | | | | | | | | | | | | | | |
| 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | |
| 熊本市長　様 | | | |  | | | | | | | | | | | | | | | |
| 請求者 | | |  | | | | | | | | | | | | | | | | |
| 法人（団体）所在地 | | |  | | | | | | | | | | | | | | | | |
| 法人（団体）名称 | | |  | | | | | | | | | | | | | | | | |
| 代表者職氏名 | | |  | | | | | | | | | | | | ㊞ | | | | |
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|  | | | 振込先  金融機関 | | | 銀行 | | | | | 支店 | | | | | | | | |
| 当座 | | | 口座番号 |  | |  | |  | |  |  |  |  |
| 普通 | | |
| 口座名義 | | |  | | | | | | | | | | | | | |