(address) <宛先>

Nagoya City West Medical Center
(community health & welfare coordination counter)
FAX No.
+81－52－991－8161

名古屋市立西部医療センター
（地域医療連携室）
FAX番号（052）991－8161

Patient Registration Form
(for proton therapy only)
<診療申込書（陽子線治療科専用）>

Applicant hospital/clinic <申込医療機関>

Hospital/clinic name ______________________________

Doctor's name ______________________________

Phone No. ______________________________

Fax No. ______________________________

Application date (YYYY/MM/DD) ______ / ______ / ______

Patient <患者>

Name	Sex	Date of birth (YYYY/MM/DD)
Phone No.: — —	M F	/ /
Address or accommodation in Japan		

<NOTICE>

Please send us not only this form but the letter of introduction (patient referral document) by FAX. <診療情報提供書も一緒にFAXお願いします>