様式第１号（第３条関係）

あんしん情報シート　　岩国市　作成日　　　　　年　　月　　日

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 氏名 | ふりがな | | | | | | 性別 | | | | | 生　年　月　日 | | | | | |
|  | | | | | | 男 ・ 女 | | | | | 年　　　月　　　日 | | | | | |
| 住所 | 岩国市 | | | | | | 自宅電話番号 | | | | |  | | | | | |
|  | | | | | | 携帯電話番号 | | | | |  | | | | | |
| 障害名（難病含む。） | | | |  | | | 手帳・等級 | | | | | 手帳 | | | | | 級 |
| 国民健康保険・後期高齢者医療保険・その他（　　　　　） | | | | | | | 血液型 | | | ＲＨ | | | ＋ | | － | 分からない | |
| 被保険者番号 | | |  | | | | Ａ | | | Ｂ | | | Ｏ | | ＡＢ |
|  | | | | | | | | | | | | | | | | | |
| かかりつけ医療機関① | | | | | | かかりつけ医療機関② | | | | | | | | | | | |
| 名称 | |  | | | | 名称 | | |  | | | | | | | | |
| 診療科目 | |  | | | | 診療科目 | | |  | | | | | | | | |
| 担当医 | |  | | | | 担当医 | | |  | | | | | | | | |
| 所在地 | |  | | | | 所在地 | | |  | | | | | | | | |
|  | | | |  | | | | | | | | |
| 電話番号 | |  | | | | 電話番号 | | |  | | | | | | | | |
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|  | | | 緊急連絡先優先① | | | | | 緊急連絡先優先② | | | | | | | | | |
| 氏名 | | |  | | | | |  | | | | | | | | | |
| 住所 | | |  | | | | |  | | | | | | | | | |
| 続柄・関係 | | |  | | | | |  | | | | | | | | | |
| 電話番号 | | |  | | | | |  | | | | | | | | | |
| 携帯電話番号 | | |  | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| 指定居宅介護支援事業者名称 | | | | |  | | | | | | | | | | | | |
| 住所 | | |  | | | | | | | | 電話番号 | | |  | | | |
|  | | | | | | | | | | | | | | | | | |
| その他救急隊員に知らせたいことなど | | | | | | | | | | | | | | | | | |
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