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| 【歯科医師と連携する時に使用します】 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 令和 | | | | | | | | | | | |  | | | | 年 | | | | |  | | | | | | 月 | | | | |  | | | 日 | | | | |
| **歯科医師連絡票** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **〈送信者記入欄↓　※歯科医師に確認したいことを記入してください〉** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **送信者** | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | **受信者** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **医療機関・事業所名** | | | | | | | |  | | |  | | | | | |  | | | | |  | | | | **歯科医院名** | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | |  | |  | | | | | |
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| **担当者：** | | | |  | | | | | | | | | | | | | | | | | | | | | | **担当者：** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **TEL：** | | | |  | | | | | | | | | | | | | | | | | | | | | | **TEL：** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **FAX：** | | | |  | | | | | | | | | | | | | | | | | | | | | | **FAX：** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **メール：** | | | |  | | | | | | | | | | | | | | | | | | | | | | **メール：** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **【照会する目的及び歯科医師からの回答希望の有無】** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 目　　的 | | | | | | 報告 | | | | | | | | | | | | | | | 連絡 | | | | | | | | | | | | | | | 相談 | | | | | | | | | | | | | | | | | | 返信 | | | | | | | | | | | | | | | |
| 回答希望の有無 | | | | | | 回答は必要です | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 回答は不要です | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **【対象者情報】** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| （ﾌﾘｶﾞﾅ） | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | | | 性別 | | | | | | | 明治 | | | | | | | |  | | | | 年 | | | |  | | | | | | 月 | | | |  | | | 日 | | | |
| 名前 | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | | | 男 | | | | | | | 大正 | | | | | | | |
| 女 | | | | | | | 昭和  平成  令和 | | | | | | | |
| 住　所 | | | | | 刈谷市○×△1-1-1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 要介護状態 | | | | | 自立 | | | | | | | | | 事業対象者 | | | | | | | | | | | | | | 要支援1 | | | | | | | | | | | | | 要支援2 | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| 要介護1 | | | | | | | | | 要介護2 | | | | | | | | | | | | | | 要介護3 | | | | | | | | | | | | | 要介護4 | | | | | | | | | | | | | | | | | 要介護5 | | | | | | | | | | | |
| **【対象者に関わっている多職種】** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏名 | | | | | | | | | | | | | | | | 事業所名 | | | | | | | | | | | | | | | | | | | | | | | | | | | 連絡先 | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **【歯科診療状況】** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| かかりつけ歯科医の有無 | | | | | | | | | | | | | | | | | | 無 | | | | | | | 有 | | | | | | | | （医院名）： | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 過去の訪問歯科診療利用状況 | | | | | | | | | | | | | | | | | | 無 | | | | | | | 有 | | | | | | | | （医院名）： | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **【連絡・照会事項】** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 対象者の現状 | | | 入れ歯の状態 | | | | | | | ⇒ | | | | | 痛み | | | | | | | | | | | | 破損 | | | | | | | | | | | | 調子が悪い | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 歯の状態 | | | | | | | ⇒ | | | | | 痛み | | | | | | | | | | | | 虫歯 | | | | | | | | | | | | とれた | | | | | | | | | | | | | グラグラする | | | | | | | | | | | | | | | | | |
| 歯茎の状態 | | | | | | | ⇒ | | | | | 痛み | | | | | | | | | | | | 出血 | | | | | | | | | | | | 腫れている | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 口腔清掃の状態 | | | | | | | ⇒ | | | | | 自立 | | | | | | | | | | | | 一部介助 | | | | | | | | | | | | 全介助 | | | | | | | | | | | | | できない | | | | | | | | | | | | | | | | | |
| 食事形態 | | | | | | | ⇒ | | | | | 普通食 | | | | | | | | | | 刻み食 | | | | | | | | | | 軟食 | | | | | | | | | | | | 流動食 | | | | | | | | | | | | | | 経管栄養 | | | | | | | | |
| その他 | | | | （ | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ） | | |
| 可能な姿勢 | | | | | | | 椅子に座れる | | | | | | | | | | | | | | | | 車いすに座る | | | | | | | | | | | | | | | ベッド等を起こした状態 | | | | | | | | | | | | | | | | | 寝たままの状態 | | | | | | | | | | | | | | |
| 《照会目的等》 | | | | | | | ※具体的に記入してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **〈歯科医師回答欄↓　※「回答が必要」とある場合は、送信者に回答してください〉** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 当連携シートで回答します | | | | | | | | | | | |  | | | | | |  | | | | |  | | | | |  | | |  | | | | | | | | | | | |  | | | |  | | | | | | | | | | | |  | | | | | | | |  |
| 直接会って話をします | | | | | | | | | | | |  | | | | | | 月 | | | | |  | | | | | 日 | | |  | | | | | | | | | | | | 頃 | | | | に　　来院希望 | | | | | | | | | | | | | | | | | | | | |
| 電話で話をします  　メールで回答します | | | | | | | | | | | |  | | | | | | 月 | | | | |  | | | | | 日 | | |  | | | | | | | | | | | | 頃 | | | | に電話を　ください　　します | | | | | | | | | | | | | | | | | | | | |
| 〈連絡・照会に対するコメント〉 | | | | | | | | | | | | | | | | | | | 特に意見はありません。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 下記のとおりです。 | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

※□はチェックボックスになっています。