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| 身体障害者更生指導台帳  自立支援医療（更生医療） | | | | |
| 障害者  氏 名 |  | | | |
|  | | | |
| 住　所 |  | | | |
| 年 月 日 | | 内容（医療の具体的方針・有効期間） | 負担上限月額 | 医療機関名 |
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○/○ ページ

**自由記載１**