Part II - Medical Certificate (to be completed by the Attending Physician, duly qualified and registered, at claimant's own expense) in relation to:

第二部份 - 醫療報告 (由索償人自費聘請主診註冊西醫填寫) 有關於:

Brain Surgery

The actual undergoing of surgery to the brain under general anaesthesia. Brain surgery during which a craniotomy is performed. Keyhole surgery is included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolizations, thrombolyhsis and stereotactic biopsy are excluded. Brain surgery as a result of an accident is excluded. The procedure must be considered necessary by a qualified specialist.

腦部外科手術

在全身麻醉下進行腦部顱骨切開手術。腦部外科手術包括鎖孔外科手術但不包括 所有不需手術切開或切除組織的治療如加碼射線、腦血管神經放射介入治療如栓 塞 形成、血栓溶解及立體定位活檢。 因意外而需要進行的腦部外科手術亦同時

除外。有關手術必須獲合資格的專科醫生認爲必須進行。

Name of Patient 病人姓名	ID / Passport No. 身份證 / 護照號碼	Age & Sex 年齡及性別	
1. Are you the patient's usual physician? 你是否病人慣常求診	的醫生?		
□ Yes, medical records date back to 是,醫療紀錄可溯至	(DD/MM/YY) 日/月/年	□ No 不是	
2. When were you first consulted for this or related illness? 病	5人首次因相同或相關病症向閣下求診的日期?		
(DD/MM/YY) 日/月/年 Sympton	ms presented were: 病徵包括 :		
3. According to the patient, how long had he / she been expet 根據病人所提供的資料,病人在首次求診前,其病徵已存在			
Since (DD/MM/YY) OR for 從 日/月/年 或已存	day(s) month(s)year(s) 字在 日 月 年		
4. (a) Clinical diagnosis 臨床診斷			
(b) When was it made? 何時確實這診斷?	(DD/MM/YY) 日/月/年		
(c) When was the patient informed of the clinical diagnosis	s?病人何時被醫生告知其所患的臨床病症及診斷?		
(DD/MM/YY) By (name & add 日/月/年 由 (醫生姓名及均	ress of physician):		
	n this illness before his / her first consultation?		
5. (a) Final diagnosis 最後診斷		_	
(b) Date of final diagnosis: 最後診斷日期	(DD/MM/YY) 日/月/年		
(c) When was the patient informed of the diagnosis? 病人何	可時被醫生告知其所患的病症及診斷?		
L L L L(DD/MM/VV) By (name & add	ress of physician):		
日/月/年 由(醫生姓名及			
6. Please provide full details of the diagnosis and its clinical ba	asis. 請提供所有診斷及臨床診斷的詳情		
	HISTORIAL PRINCIPLE PRINCIPLE PRINCIPLE IN THE PRINCIPLE		
7. Was the patient referred to you from other physician(s)?	病人是否由其他醫生 轉介?		
☐ Yes, (DD/MM/YY) By (name 8	& address of physician):	□ No 不是	
是, 日/月/年 由(醫生姓	名及地址):		
8. Has the patient ever been treated for the same/related con	nditions?病人有否曾經接受相同/相關的病症治療?		
☐ Yes, please provide details:有,請詳述:		□ No 沒有	
Consultation Dates (DD/MM/YY) Physician / Hospital	<u>Diagnosis</u> <u>Treatment and Investigation R</u>	<u>Results / Hospitalization</u>	
就診日期 日/月/年 醫生/ 醫院全名	診斷 任何醫療診治及檢查結果/住院	元評情	

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9.	Is there any patient's family history which would increase the risk of this illness? 病	人是否因其任何	可的家族病史而增加患上此疾病的機	會?
	□ Yes, please provide details : 有,請詳述 :			☐ No 沒有
10.	10. Does the patient smoke cigarette? 病人是否有吸煙習慣? Yes, has been smoking since 有,由 (DD/MM/YY)日/月/年開始吸煙			
	□ Ex-smoker, started on (DD/MM/YY),ceased on (日/月/年), 於		_ (DD/MM/YY) (日/月/年) 停止	
11.	All consultants, specialists and hospitals to which your patient has been referred to 病人因此病症而曾接受過診治的,或曾被轉介過的所有醫生 (普通科及專科) 和醫院的		or this illness	
	Consultation Date (DD/MM/YY) Physician / Hospital Diagnosis 就診日期 日/月/年 醫生/ 醫院全名 診斷		and Investigation Results / Hospitali 治及檢查結果 / 住院詳情	zation_
12.	Name, date and details of the brain surgery performed. 請提供該腦部外科手術的名稱,進行日期及詳情。			
13.	Is the brain surgery required as a result of any event of accident? 該腦部外科手術是否因爲意外而需要進行?			
	□ Yes, details of the accident are: 是,意外的詳情是:			
	□ No, the underlying cause(s) leading to this brain surgery is/are: 不是,導致進行此腦部外科手術的原因是:			
14.	Is general anaesthesia used during the brain surgery? What was the reason? 該腦部外科手術是否在全身麻醉下進行? 請說明理由。			
15.	What is the prognosis of the patient? 病人現時進展及狀況			
16.	What tests were performed to confirm the diagnosis? (Please enclose copies of all 有什麼檢驗結果讓閣下能確定此診斷? (請提供有關檢驗報告及醫療報告副本)	laboratory rep	orts and relevant medical reports th	at are available)
	Test Date (DD/MM/YY) 檢驗日期(日/月/年) Test Item 檢驗項目	<u>Result /</u>	Diagnosis 結果/診斷	
17.	Other additional information for the current diagnosis 其他有關此診斷結果之額外資料			
Ho 醫	spital Name (if applicable) T 竞名稱(如適用)	資歷 Telephone No 辩絡電話		
地 Sig	nature & Hospital/ Physician's Chop	Date (DD/MM/Y 日期 (日/月/年)	Y)	