CRISIS COVER CLAIM FORM 危疾理賠申請書 Policy No. 保單號碼 _____

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 :

Multiple Sclerosis
Unequivocal diagnosis by a specialist neurologist and confirmed by modern investigational techniques such as image scanning confirming more than one episode of well-defined neurological symptoms, with persisting signs or involvement of the optic nerves, brain stem and spinal cord together with impairment of co-ordination and motor and sensory function, with the Life Assured not necessarily confined to a wheel chair.

多發性硬化症
由神經專科醫生明確診斷，並經過影像掃描等現代化診症技術核實，出現多於1次明顯的神經科徵狀，持續出現或涉及視覺神經、腦幹及脊柱方面的症狀，並且有身體協調及運動、感官功能受損，但受保人不一定需要受困於輪椅。

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 Symptoms presented were: 病徵包括 : _____

3. According to the patient, how long had he / she been experiencing these symptoms before the first consultation?
根據病人所提供的資料，病人在首次求診前，其病徵已存在多久?

Since |_____|_____|_____| (DD/MM/YY) OR for _____day(s)_____ month(s) _____year(s)
從 日/月/年 或 已存在 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? 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 & address of physician): _____
日/月/年 由 (醫生姓名及地址)

(d) How long, in your opinion, has the patient suffered from this illness before his / her first consultation? _____
根據閣下的意見，病人在接受第一次診療之前，該病症已持續了多久?

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? 病人何時被醫生告知其所患的病症及診斷?

|_____|_____|_____| (DD/MM/YY) By (name & address of physician): _____
日/月/年 由 (醫生姓名及地址) :

6. Please provide full details of the diagnosis and its clinical basis. 請提供所有診斷及臨床診斷的詳情

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 & 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 conditions** ? 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) 就診日期 日/月/年	Physician / Hospital 醫生/ 醫院全名	Diagnosis 診斷	Treatment and Investigation Results / Hospitalization 任何醫療診治及檢查結果 / 住院詳情

9. Is there any patient's family history which would increase the risk of this illness? 病人是否因其任何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. 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 ❒ No 沒有

❒ Ex-smoker, started on|_____|_____|_____| (DD/MM/YY),ceased on |_____|_____|_____| (DD/MM/YY)
前吸煙者 ， 開始於 (日/月/年) , 於 (日/月/年) 停止

11. All consultants, specialists and hospitals to which your patient has been referred to or attended for this illness
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) 和醫院的名稱

Consultation Date (DD/MM/YY) 就診日期 日/月/年	Physician / Hospital 醫生/ 醫院全名	Diagnosis 診斷	Treatment and Investigation Results / Hospitalization 任何醫療診治及檢查結果 / 住院詳情

12. Are there more than one episode of well-defined neurological symptoms with persisting signs of involvement of the optic nerves, brain stem and spinal cord?
病人有否出現多於一次明顯的神經科徵狀，持續出現或涉及視覺神經、腦幹及脊柱方面的症狀?

❒ Yes, please provide details and enclose copies of all laboratory reports and relevant medical reports ❒ No 沒有
有，請詳述及提供有關檢驗報告及醫療報告副本

13. Is there any impairment of co-ordination and motor and sensory function? 病人的身體協調及運動、感官功能有否受損?

❒ Yes, please describe to what extent : ❒ No 沒有
有，請詳述其程度:

14. Was there a history of repeated relapse and remission of steady progressive disability? 病人的漸進式殘疾有否重複出現復發及緩解的病史?

❒ Yes, please provide details: ❒ No 沒有
是，請詳述:

15. What tests / investigations were performed to confirm the diagnosis of **Multiple Sclerosis**? (Please enclose copies of all laboratory reports and relevant medical reports that are available)
有什麼檢驗結果讓閣下能確定此**多發性硬化症**的診斷? (請提供有關檢驗報告及醫療報告副本)

Test / Investigation Date (DD/MM/YY) 化驗/檢驗日期(日/月/年)	Test / Investigation Item 化驗/檢驗項目	Result / Diagnosis 結果/診斷

16. What is the prognosis of the patient? 病人現時進展及狀況

17. Other additional information for the current diagnosis 其他有關此診斷結果之額外資料

Name of Physician _____ Qualification _____
醫生姓名 資歷
Hospital Name (if applicable) _____ Telephone No._____
醫院名稱(如適用) 聯絡電話
Address_____
地址
Signature & Hospital/ Physician's Chop _____ Date (DD/MM/YY) _____
醫院/ 醫生簽署及蓋印 日期 (日/月/年)