

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 :

<p><b>Blindness</b> Total and irrecoverable loss of sight in both eyes.</p> <p><b>失明</b> 雙眼完全失明並不可復原。</p>
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Name of Patient 病人姓名	ID / Passport No. 身份證 / 護照號碼	Age & Sex 年齡及性別
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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

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