

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>Cardiomyopathy Cardiomyopathy as diagnosed by a specialist cardiologist characterized by impaired ventricular function of unknown aetiology with permanent and irreversible physical impairment to the degree of class 4 of the New York Heart Association Classification of cardiac impairment. Your benefit does not cover Cardiomyopathy directly related to alcohol or drug usage.</p> <p>心肌病 由心臟專科醫生診斷為由病因不明的心室功能損傷引致的心肌病，而具永久及不可復原的體能障礙，程度達紐約心臟協會心臟障礙級別的第4級。 閣下的保障不包括因服用酒精或藥物直接引致的心肌病。</p>

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? <input type="checkbox"/> Yes, medical records date back to 是, 醫療紀錄可溯至 _____ _____ _____ (DD/MM/YY) 日/月/年 <input type="checkbox"/> 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? <input type="checkbox"/> Yes, _____ _____ _____ (DD/MM/YY) By (name & address of physician): _____ <input type="checkbox"/> 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? <input type="checkbox"/> Yes, please provide details : 有, 請詳述: <input type="checkbox"/> No 沒有 <table border="0"> <tr> <td><u>Consultation Dates</u> (DD/MM/YY)</td> <td><u>Physician / Hospital</u></td> <td><u>Diagnosis</u></td> <td><u>Treatment and Investigation Results / Hospitalization</u></td> </tr> <tr> <td>就診日期 日/月/年</td> <td>醫生/ 醫院全名</td> <td>診斷</td> <td>任何醫療診治及檢查結果 / 住院詳情</td> </tr> </table>			<u>Consultation Dates</u> (DD/MM/YY)	<u>Physician / Hospital</u>	<u>Diagnosis</u>	<u>Treatment and Investigation 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 / 住院詳情
<u>Consultation Dates</u> (DD/MM/YY)	<u>Physician / Hospital</u>	<u>Diagnosis</u>	<u>Treatment and Investigation 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?		<input type="checkbox"/> No 沒有
	<input type="checkbox"/> Yes, please provide details : 有, 請詳述 : _____		
10.	Does the patient smoke cigarette? 病人是否有吸煙習慣?		<input type="checkbox"/> No 沒有
	<input type="checkbox"/> Yes, has been smoking since 有, 由 _____ _____ _____ (DD/MM/YY) 日/月/年開始吸煙		
	<input type="checkbox"/> 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		
	<u>Consultation Dates (DD/MM/YY)</u> <u>Physician / Hospital</u> <u>Diagnosis</u> <u>Treatment and Investigation Results / Hospitalization</u> 就診日期 日/月/年 醫生/ 醫院全名 診斷 診治及研究結果/住院詳情		
12.	What is the degree of severity of the cardiomyopathy in terms of ventricular function? Please provide the details. 請依據心室功能以詳述心肌病的嚴重程度。		
13.	Was the impaired ventricular function with permanent and irreversible physical impairment? 病人的心室功能損傷是否具永久及不可復原的體能障礙?		<input type="checkbox"/> No 不是
	<input type="checkbox"/> Yes, please provide details : 是, 請詳述 : _____		
14. (a)	What is the cardiac impairment class of the patient according to the New York Heart Association (NYHA) classification? 根據紐約心臟協會心臟障礙級別, 病人的心臟障礙級別多少?		
	(b) If NYHA classification is not used, what was the classification used and what condition(s) do(es) that particular class indicate? 若果沒有以紐約心臟協會心臟障礙級別評級, 閣下引用了那個評級及該評級顯示了那個情況?		
15. (a)	What is/are the underlying cause(s) leading to cardiomyopathy of this patient? 什麼原因引致病人的心肌病?		
	(b) Was the patient's cardiomyopathy secondary to alcohol or drug usage? 病人的心肌病是否由服用酒精或藥物所引起?		<input type="checkbox"/> No 不是
	<input type="checkbox"/> Yes, please provide details.: 是, 請詳述	<input type="checkbox"/> Alcohol 酒精	<input type="checkbox"/> Drug 藥物
	Types 種類 Consumption Pattern / Dosage 服用習慣 / 劑量 No. of years consumption 服用年期 Was it on prescription? 是否經處方?		
16.	What tests were performed to confirm the diagnosis? (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診斷? (請提供有關檢驗報告及醫療報告副本)		
	<u>Test Date (DD/MM/YY)</u> 檢驗日期(日/月/年) <u>Test Item</u> 檢驗項目 <u>Result / Diagnosis</u> 結果/ 診斷		
17.	What is the prognosis of the patient? 病人現時進展及狀況		
18.	Other additional information for the current diagnosis 其他有關此診斷結果之額外資料		
	Name of Physician _____ 醫生姓名	Qualification _____ 資歷	
	Hospital Name (if applicable) _____ 醫院名稱(如適用)	Telephone No _____ 聯絡電話	
	Address _____ 地址		
	Signature & Hospital/ Physician's Chop _____ 醫院/ 醫生簽署及蓋印	Date (DD/MM/YY) _____ 日期 (日/月/年)	

