**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 :**

**Deafness**
Total permanent and irreversible loss of hearing in both ears.

**失聰**
雙耳完全失去聽覺並不可復原。

| 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. What was the cause of the loss of hearing? 什麼原因引致病人的失去聽覺?

13. (a) Please provide details of all investigations and tests carried out, e.g. audiogram, magnetic resonance imagining (MRI).
請詳述病人曾接受的所有測試, 如聽力圖, 磁力共振

| Test Date (DD/MM/YY) 測試日期(日/月/年) | Test Item 測試項目 | Result / Diagnosis 結果/診斷 |
|---|---|---|
| | | |

(b) What kinds of treatment are currently provided and / or will be provided to the patient? 病人現正/將會接受什麼類型的治療?

(c) Is there any other surgery/treatment helps to improve the patient's hearing in either one or both ears? 有否手術或治療可改善病人單耳或雙耳的聽力?

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

(d) Are there any plans to conduct further tests? 有否計劃進行其他測試?

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

14. Was the loss of hearing permanent and irrecoverable in both ears? (Please enclose copies of all supportive reports and relevant medical reports that are available).
病人的雙耳是否完全失去聽覺並不可復原? (請提供有關檢驗報告及醫療報告副本)

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

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

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

16. 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)