

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 :

Encephalitis Severe inflammation of brain substance which results in significant and permanent neurological sequelae as certified by a specialist neurologist. 腦炎 由神經專科醫生證實的嚴重腦質發炎，並導致嚴重及永久的神經病後遺症。											
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): _____ 是, _____ 日/月/年 由 (醫生姓名及地址): <input type="checkbox"/> No 不是											
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								



<p>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?</p> <p><input type="checkbox"/> Yes, please provide details : 有, 請詳述 : _____</p>	<input type="checkbox"/> No 沒有				
<p>10. Does the patient smoke cigarette? 病人是否有吸煙習慣?</p> <p><input type="checkbox"/> Yes, has been smoking since 有, 由 _____ _____ _____ (DD/MM/YY)日/月/年開始吸煙</p> <p><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</p>	<input type="checkbox"/> No 沒有				
<p>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</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><u>Consultation Date</u> (DD/MM/YY) 就診日期 日/月/年</td> <td style="width: 25%;"><u>Physician / Hospital</u> 醫生/ 醫院全名</td> <td style="width: 25%;"><u>Diagnosis</u> 診斷</td> <td style="width: 25%;"><u>Treatment and Investigation Results / Hospitalization</u> 任何醫療診治及檢查結果 / 住院詳情</td> </tr> </table>		<u>Consultation Date</u> (DD/MM/YY) 就診日期 日/月/年	<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
<u>Consultation Date</u> (DD/MM/YY) 就診日期 日/月/年	<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		
<p>12. What tests (e.g. CT scan of brain) were performed? Please provide details such as date and results of these tests. 病人進行了什麼檢驗? 請提供有關檢驗的詳情, 如進行日期及結果</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><u>Test Date</u> (DD/MM/YY) 檢驗日期(日/月/年)</td> <td style="width: 33%;"><u>Test Item</u> 檢驗項目</td> <td style="width: 33%;"><u>Result / Final Diagnosis</u> 結果/ 最後診斷</td> </tr> </table>		<u>Test Date</u> (DD/MM/YY) 檢驗日期(日/月/年)	<u>Test Item</u> 檢驗項目	<u>Result / Final Diagnosis</u> 結果/ 最後診斷	
<u>Test Date</u> (DD/MM/YY) 檢驗日期(日/月/年)	<u>Test Item</u> 檢驗項目	<u>Result / Final Diagnosis</u> 結果/ 最後診斷			
<p>13. Please specify the severity of encephalitis in terms of any destruction of neurological function. 請根據神經功能的破壞情況, 詳述腦炎的嚴重程度。</p>					
<p>14. Is there any permanent neurological sequelae resulted from the encephalitis? 腦炎有否導致永久性神經功能缺陷?</p> <p><input type="checkbox"/> Yes, please describe in terms of neurological function. 有, 請就其神經功能詳述:</p>	<input type="checkbox"/> No 沒有				
<p>15. What treatment is currently being administered? Please enclose copies of all test reports and any relevant hospital reports that are available. 現時向病人提供了什麼治療? (請提供有關檢驗報告及醫療報告副本)</p>					
<p>16. What is/are the underlying cause(s) leading to the patient's encephalitis? 什麼原因引致病人的腦炎?</p>					
<p>17. 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)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><u>Test Date</u> (DD/MM/YY) 檢驗日期(日/月/年)</td> <td style="width: 33%;"><u>Test Item</u> 檢驗項目</td> <td style="width: 33%;"><u>Result / Final Diagnosis</u> 結果/ 最後診斷</td> </tr> </table>		<u>Test Date</u> (DD/MM/YY) 檢驗日期(日/月/年)	<u>Test Item</u> 檢驗項目	<u>Result / Final Diagnosis</u> 結果/ 最後診斷	
<u>Test Date</u> (DD/MM/YY) 檢驗日期(日/月/年)	<u>Test Item</u> 檢驗項目	<u>Result / Final Diagnosis</u> 結果/ 最後診斷			
<p>16. What is the prognosis of the patient? 病人現時進展及狀況</p>					
<p>17. Other additional information for the current diagnosis 其他有關此診斷結果之額外資料</p>					
<p>Name of Physician _____ 醫生姓名</p> <p>Hospital Name (if applicable) _____ 醫院名稱(如適用)</p> <p>Address _____ 地址</p> <p>Signature & Hospital/ Physician's Chop _____ 醫院/ 醫生簽署及蓋印</p>	<p>Qualification _____ 資歷</p> <p>Telephone No. _____ 聯絡電話</p> <p>Date (DD/MM/YY) _____ 日期 (日/月/年)</p>				

