

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 :

End Stage Lung Disease

End stage lung disease including interstitial lung disease requiring permanent oxygen therapy as well as a FEV 1 test result of consistently less than 1 litre.

末期肺病

末期肺病包括間質性肺病，需要永久接受氧氣治療及1秒用力呼氣量（FEV 1）測試結果持續少於1公升。

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
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<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;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Consultation Date (DD/MM/YY) 就診日期</th> <th style="text-align: left; border-bottom: 1px solid black;">Physician / Hospital 醫生 / 醫院全名</th> <th style="text-align: left; border-bottom: 1px solid black;">Diagnosis 診斷</th> <th style="text-align: left; border-bottom: 1px solid black;">Treatment and Investigation Results / Hospitalization 任何醫療診治及檢查結果 / 住院詳情</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>		Consultation Date (DD/MM/YY) 就診日期	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				
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<p>12. What kind of end stage lung disease does the patient suffer? 病人患有那類型的末期肺病?</p>									
<p>13. Does the patient's end stage lung disorder require extensive and permanent oxygen therapy? If so, when did it start? 病人的末期肺病是否需要大規模及永久的氧氣治療?</p> <p><input type="checkbox"/> Yes, it started on _____ _____ _____ (DD/MM/YY) 是, 開始於 _____ (日/月/年)</p> <p>Details: 請詳述:</p>		<input type="checkbox"/> No 沒有							
<p>14. Please give dates and results of all investigations carried out such as pulmonary function tests, FEV 1 test and vital capacity readings. (Please enclose copies of all supportive reports and relevant medical reports that are available). 請提供如肺功能、1秒用力呼氣量(FEV 1)及肺活量讀數的所有測試的日期及結果 (請提供有關檢驗報告及醫療報告副本)</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Test Date (DD/MM/YY) 檢驗日期(日/月/年)</th> <th style="text-align: left; border-bottom: 1px solid black;">Test Item 檢驗項目</th> <th style="text-align: left; border-bottom: 1px solid black;">Result / Diagnosis 結果/診斷</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"> </td> <td> </td> <td> </td> </tr> </tbody> </table>		Test Date (DD/MM/YY) 檢驗日期(日/月/年)	Test Item 檢驗項目	Result / Diagnosis 結果/診斷					
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<p>15. What is/are the underlying cause(s) leading to the end stage lung disease of this patient? 什麼原因引致病人的末期肺病?</p>									
<p>16. Has the patient ever been exposed to any substance that is likely to increase the risk of lung disease (whether through his/her occupation or not)? 病人有否接觸過一些有機會增加患上肺病的物質 (不論是否與其職業有關)</p> <p><input type="checkbox"/> Yes, please provide details 有, 請詳述</p>		<input type="checkbox"/> No 沒有							
<p>17. What is the prognosis of the patient? 病人現時進展及狀況</p>									
<p>18. 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>								

