

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 :

Fulminant Viral Hepatitis

This involves a submassive to massive necrosis of the liver caused by viral hepatitis leading precipitously to liver failure, excluding drug and alcohol abuse as certified by a Registered Doctor. The diagnostic criteria which is required to be met are:

- a rapidly decreasing liver size; and
- necrosis involving entire lobules, leaving only a collapsed reticular framework; and
- rapidly degenerating liver function tests; and
- deepening jaundice.

暴發性病毒肝炎

由病毒性肝炎引起的亞全部或全部肝臟壞死，導致突發性肝衰竭，但不包括由註冊醫生證明因藥物及酒精濫用引致的情況，並須符合下列的診斷標準：

- 肝臟急劇縮小；及
- 整塊肝葉壞死，只餘下萎陷的網狀支架；及
- 肝功能測試急劇退化；及
- 黃疸加深。

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 style="width: 100%; border: none;"> <tr> <td style="width: 25%;"><u>Consultation Dates</u> (DD/MM/YY)</td> <td style="width: 25%;"><u>Physician / Hospital</u></td> <td style="width: 25%;"><u>Diagnosis</u></td> <td style="width: 25%;"><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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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

<u>Consultation Date (DD/MM/YY)</u> 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

12. (a) Is there any necrosis of the liver? 肝臟有否出現壞死?
 Yes, please provide details 有, 請詳述: _____ No 沒有

(b) What is the extent of the liver necrosis? Is it massive or submassive? 病人的肝臟壞死屬於亞全部還是全部? 及其程度如何??
 Massive, evidence(s) is / are 全部, 證明是:
 Submassive, evidence(s) is / are 亞全部, 證明是:

(c) Please specify the extension of necrosis in terms of lobules involvement (entire or partial lobules, and if leaving a collapsed reticular framework).
請依據肝葉受影響範圍 (如整塊或部分肝葉, 及只餘下萎陷的網狀支架) 以詳述肝臟壞死的程度。

(d) What is/are the cause(s) leading to the liver necrosis of this patient? 什麼原因引致病人的慢性肝臟壞死?

(e) Please enclose copies of all laboratory reports and relevant medical reports (請提供有關檢驗報告及醫療報告副本)。



<p>13. Was the patient's liver failure secondary to alcohol or drug misuse? 病人的肝衰竭是否由誤用酒精或藥物所引起?</p> <p><input type="checkbox"/> Yes, please provide details 是, 請詳述: <input type="checkbox"/> Alcohol 酒精 <input type="checkbox"/> Drug 藥物 <input type="checkbox"/> No 不是</p> <p>Types 種類 _____</p> <p>Consumption Pattern / Dosage 服用習慣 / 劑量 _____</p> <p>No. of years consumption 服用年期 _____</p> <p>Was it on prescription? 是否經處方? _____</p>	
<p>14. Please describe the extent of the disease with the following evidence presented? (Please enclose copies of all laboratory reports and relevant medical reports). 請詳述病情是否具備下列證明 (請提供有關檢驗報告及醫療報告副本).</p> <p>(a) Rapid decrease in liver size 肝臟急劇縮小 <input type="checkbox"/> Yes, evidence(s) is / are (e.g. size before and after the disease): 有, 證明是 (如病發前後肝臟的大小): <input type="checkbox"/> No 沒有</p> <p>(b) Rapid degeneration of liver function test 肝功能測試急劇退化 <input type="checkbox"/> Yes, evidence(s) is / are (e.g. liver function test results) 有, 證明是 (如肝功能測試的結果): <input type="checkbox"/> No 沒有</p> <p>(c) Deepening jaundice 黃疸加深 <input type="checkbox"/> Yes, evidence(s) is / are: 有, 證明是: <input type="checkbox"/> No 沒有</p>	
<p>15. What is the prognosis of the patient? 病人現時進展及狀況</p>	
<p>16. 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>

