

Part II Medical Certificate (to be completed by the Attending Physician, 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:

Multiple Sclerosis (Definition Before 2017)

Unequivocal diagnosis by a Registered Specialist Neurologist and confirmed by modern investigational techniques such as image scanning confirming more than one episode of well-defined neurological symptoms, with persisting signs or involvement of the optic nerves, brain stem and spinal cord together with impairment of co-ordination and motor and sensory function, with the Life Assured not necessarily confined to a wheel chair.

多發性硬化症 (二零一七年前之定義)

由註冊腦神經科專科醫生明確診斷，並經過影像掃描等現代化診症技術核實，出現多於1次明顯的神經科徵狀，持續出現或涉及視覺神經、腦幹及脊柱方面的症狀，並且有身體協調及運動、感官功能受損，但受保人不一定需要受困於輪椅。

Multiple Sclerosis (Definition from 2017 onwards)

Unequivocal diagnosis of Multiple Sclerosis by a Registered Specialist Neurologist, and which confirms the following:

- objective clinical evidence of ≥ 1 T2 lesion in at least 2 out of 4 regions of the central nervous system as mentioned below:

- (i) Periventricular;
- (ii) Juxtacortical;
- (iii) Infratentorial;
- (iv) spinal cord;

and

- more than one episode of well-defined neurological symptoms involving the optic nerves, brain stem, spinal cord, coordination or motor function; and
- a well-documented history of exacerbations and remissions of neurological symptoms over a period of more than 6 months.

多發性硬化症 (二零一七年起之定義)

由註冊腦神經科專科醫生明確診斷為多發性硬化症，並確定下列各項：

- 以下四個中樞神經系統區域中最少兩個區域有 ≥ 1 個T2病變的客觀臨床證據：

- (i) 腦室周圍；
- (ii) 近腦皮質；
- (iii) 小腦幕下；
- (iv) 脊髓；

及

- 出現多於1次明顯的神經科徵狀，涉及視覺神經、腦幹、脊髓、身體協調或運動功能；及
- 對神經科徵狀的病徵有六個月以上詳細的病歷記錄，包括病情變壞及復原的病史。

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 dated 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 his/her illness(es)? 病人首次因此疾病向閣下求診的日期是那日? _____ (DD/MM/YY) (日/月/年) Presenting signs & symptoms 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，已經歷其病狀多久? 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? 何時確診這診斷? _____ (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) (日/月/年) by (name & address of physician) 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 最終診斷日期 |_____|_____|_____| (DD/MM/YY) (日/月/年)

(c) Date the patient was informed of the diagnosis 病人被告知最後診斷的日期為
 |_____|_____|_____| (DD/MM/YY) (日/月/年) By (name & address of physician) 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, 是 |_____|_____|_____| (DD/MM/YY) (日/月/年) No 不是

By (name & address of physician) 由(醫生姓名及地址): _____

8. Has the patient ever been treated for the same / related conditions? 病人是否曾經接受相同 / 相關的病症治療?

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

<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

9. Is there any patient's family history which would increase the risk of the above final diagnosis? 病人是否有任何既往家族病史而增加上述最終診斷的風險?

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

Ex-smoker, started on 前吸煙者, 開始於 |_____|_____|_____| (DD/MM/YY) (日/月/年),
 ceased on 於|_____|_____|_____| (DD/MM/YY) (日/月/年) 停止

11. All consultations, 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. Does the patient has the following condition?

病人是否有以下的狀況?

objective clinical evidence of ≥ 1 T2 lesion in at least 2 out of 4 regions of the central nervous system as mentioned below

以下四個中樞神經系統區域中最少兩個區域有 ≥ 1 個T2病變的客觀臨床證據

- Yes 有 No 沒有 Periventricular 腦室周圍
 Yes 有 No 沒有 Juxtacortical 近腦皮質
 Yes 有 No 沒有 Infratentorial 小腦幕下
 Yes 有 No 沒有 spinal cord 脊髓

more than one episode of well-defined neurological symptoms

出現多於1次明顯的神經科徵狀，涉及視覺神經、腦幹、脊髓、身體協調或

- Yes 有 No 沒有 optic nerves 視覺神經；
 Yes 有 No 沒有 brain stem 腦幹；
 Yes 有 No 沒有 spinal cord 脊髓；
 Yes 有 No 沒有 coordination 身體協調；
 Yes 有 No 沒有 motor function 運動功能；

a well-documented history of exacerbations and remissions of neurological symptoms over a period of more than 6 months.

對神經科徵狀的病徵有六個月以上詳細的病歷記錄，包括病情變壞及復原的病史。

Yes 有 Please provide all the medical records 請提供所有病歷記錄

No 沒有

13. Is there any impairment of co-ordination and motor and sensory function ?

病人的身體協調及運動、感官功能有否受損？

Yes, please provide details. 有，請詳述其程度。

No 沒有

14. Was there a history of repeated relapse and remission of steady progressive disability?

病人的漸進式殘疾有否重複出現復發及緩解的病史？

Yes, please provide details. 有，請詳述其程度。

No 沒有

15. 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? (請提供檢驗報告及醫療報告副本)

Test Date (DD/MM/YY)

檢驗日期 日/月/年

Test Item

檢驗項目

Diagnosis/ Result

診斷/ 結果

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

17. Other additional information for the current diagnosis 其他有關此診斷結果之額外資料

Name of Attending Physician _____
主診醫生姓名

Qualification _____
專業資格

Hospital Name (if applicable) _____
醫院名稱(如適用)

Telephone No. _____
電話號碼

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)