

**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 :**

**Primary Pulmonary Arterial Hypertension**  
 Primary pulmonary arterial hypertension as established by clinical and laboratory investigations (including cardiac catheterization) and as diagnosed by a specialist cardiologist. The following diagnostic criteria must be met:

dyspnoea and fatigue; and  
 increased left atrial pressure (at least 20 units more); and  
 pulmonary resistance of at least 3 units above normal; and  
 pulmonary artery pressure of at least 40mmHg; and  
 pulmonary wedge pressure of at least 6mmHg; and  
 right ventricular end-diastolic pressure of at least 8mmHg; and  
 right ventricular hypertrophy, dilation and signs of right heart failure and decompensation.

**原發性肺動脈高血壓**  
 根據臨床及檢驗 (包括心導管檢查) 證實, 並由心臟科專科醫生診斷, 並須符合下列診斷標準:

呼吸困難及疲倦; 及  
 左心房血壓上升 (最少超越20個單位); 及  
 肺阻力比正常水平最少高出3個單位; 及  
 肺動脈壓最少為 40mmHg; 及  
 肺楔壓最少為 6mmHg; 及  
 右心室舒張末期壓最少為8mmHg; 及  
 右心室肥大、擴張以及右心室出現衰竭及代償失調的徵狀。

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 <span style="float:right;"><input type="checkbox"/> No 不是</span>		
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): _____ <span style="float:right;"><input type="checkbox"/> No 不是</span> 是, _____ 日/月/年 由 (醫生姓名及地址): _____		



<p>8. Has the patient ever been treated for the <b>same/related conditions</b>? 病人有否曾經接受<b>相同/相關</b>的病症治療?</p> <p><input type="checkbox"/> Yes, please provide details: 有, 請詳述: _____ <span style="float: right;"><input type="checkbox"/> No 沒有</span></p> <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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<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: _____ <span style="float: right;"><input type="checkbox"/> No 沒有</span></p>															
<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 <span style="float: right;"><input type="checkbox"/> No 沒有</span></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>															
<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: none;"> <tr> <td style="width: 25%;"><u>Consultation Date</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 Date</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>12. What is/are the underlying cause(s) leading to the patient's pulmonary arterial hypertension? 什麼原因引致病人的肺動脈高血壓?</p>															
<p>13. Was cardiac catheterization performed? 有沒有進行心導管檢查?</p> <p><input type="checkbox"/> Yes, result was: 有, 結果是: _____ <span style="float: right;"><input type="checkbox"/> No 沒有</span></p>															
<p>14. Please describe the extent of the pulmonary arterial hypertension 請詳述肺動脈高血壓的程度。</p> <p>(a) Was there dyspnoea and fatigue? 有否呼吸困難及疲倦? <input type="checkbox"/> Yes 有 <span style="float: right;"><input type="checkbox"/> No 沒有</span></p> <p>(b) Was there any increase in the left atrial pressure? <input type="checkbox"/> Yes, 有 <span style="float: right;"><input type="checkbox"/> No 沒有</span> 左心房血壓有否上升? Increased Level Reading (unit): 上升的讀數(單位): Normal Level Reading (unit): 正常的讀數(單位):</p> <p>(c) Was there any increase in the pulmonary resistance? <input type="checkbox"/> Yes, 有 <span style="float: right;"><input type="checkbox"/> No 沒有</span> 肺阻力比正常水平有否上升? Increased Level Reading (unit): 上升的讀數(單位): Normal Level Reading (unit): 正常的讀數(單位):</p> <p>(d) Was there any increase in the pulmonary artery pressure? <input type="checkbox"/> Yes, 有 <span style="float: right;"><input type="checkbox"/> No 沒有</span> 肺動脈壓有否上升? Increased Level Reading (mmHg): 上升的讀數(mmHg): Normal Level Reading (mmHg): 正常的讀數(mmHg):</p> <p>(e) Was there any increase in the pulmonary wedge pressure? <input type="checkbox"/> Yes, 有 <span style="float: right;"><input type="checkbox"/> No 沒有</span> 肺楔壓有否上升? Increased Level Reading (mmHg): 上升的讀數(mmHg): Normal Level Reading (mmHg): 正常的讀數(mmHg):</p> <p>(f) Was there any increase in the right ventricular end-diastolic pressure? <input type="checkbox"/> Yes, 有 <span style="float: right;"><input type="checkbox"/> No 沒有</span> 右心室舒張末期壓有否上升? Increased Level Reading (mmHg): 上升的讀數(mmHg): Normal Level Reading (mmHg): 正常的讀數(mmHg):</p> <p>(g) Was there any sign of 有否以下徵狀</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 40%;">(i) right ventricular hypertrophy 右心室肥大</td> <td style="width: 20%;"><input type="checkbox"/> Yes 有</td> <td style="width: 40%;"><input type="checkbox"/> No 沒有</td> </tr> <tr> <td>(ii) right ventricular hypertrophy dilation 右心室擴張</td> <td><input type="checkbox"/> Yes 有</td> <td><input type="checkbox"/> No 沒有</td> </tr> <tr> <td>(iii) right heart failure 右心室衰竭</td> <td><input type="checkbox"/> Yes 有</td> <td><input type="checkbox"/> No 沒有</td> </tr> <tr> <td>(iv) right heart decompensation 右心室代償失調</td> <td><input type="checkbox"/> Yes 有</td> <td><input type="checkbox"/> No 沒有</td> </tr> </table>				(i) right ventricular hypertrophy 右心室肥大	<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 沒有	(ii) right ventricular hypertrophy dilation 右心室擴張	<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 沒有	(iii) right heart failure 右心室衰竭	<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 沒有	(iv) right heart decompensation 右心室代償失調	<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 沒有
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<p>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? (請提供有關檢驗報告及醫療報告副本)</p> <table style="width: 100%; border: none;"> <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 / Histopathological Diagnosis</u> 結果/ 病理組織診斷</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 / Histopathological Diagnosis</u> 結果/ 病理組織診斷									
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<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 &amp; 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>													

