CRISIS COVER CLAIM FORM 危疾理賠申請書 Policy No. 保單號碼 _____

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 :

Major Head Trauma
Accidental head injuries resulting in residual brain damage to the extent that there is a permanent neurological deficit causing Significant Functional Impairment. "Significant Functional Impairment" means a consultant neurologist has assessed the Life Assured as scoring 5 or less on the eight point version of the Glasgow Outcome Scale of Head Injuries or equivalent levels of functional impairment on a similar scale which has been generally accepted in medical literature.

嚴重頭部創傷
意外的頭部受傷導致殘餘腦部損傷，達到持久性神經系統缺陷的程度，並引起重要的功能損害。「重要的功能損害」指受保人被腦神經專科醫生以格拉斯哥之頭部損傷結果尺度(Glasgow Outcome Scale of Head Injuries)的第8.0版本評估而獲得5分或以下，或於獲醫學文獻接受的類似尺度中表示相等程度的功能損害。

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?

☐ Yes, medical records date back to 是，醫療紀錄可溯至 |_____|_____|_____| (DD/MM/YY) 日/月/年 ☐ No 不是

2. When were you first consulted for this condition of head trauma? 病人首次因頭部創傷向閣下求診的日期?

|_____|_____|_____| (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. 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

5. Was the patient **referred to** you from other physician(s)? 病人是否由其他醫生**轉介**?

☐ Yes, |_____|_____|_____| (DD/MM/YY) By (name & address of physician): _____ ☐ No 不是
是， 日/月/年 由 (醫生姓名及地址) :

6. 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 ?

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

Consultation Dates (DD/MM/YY) 就診日期 日/月/年	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

7. 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

8. 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

9. 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

Consultation Date (DD/MM/YY) 就診日期 日/月/年	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

10. Please provide the full details of the accident leading to head trauma.
請提供導致該頭部創傷的意外詳情

(a) Date & Time
日期及時間

(b) Location
地點

(c) Where and how did it happen? (Describe activities engaged if applicable)
意外如何發生及事發地點 (如適用, 請形容當時進行之活動)

11. Is there any residual brain damage resulting from the head trauma?
該頭部創傷有否導致殘餘腦部損傷?
lease provide details : ☐ No 沒有
☐ 有，請詳述 :

12. (a) Is there any neurological sequelae resulting from the head trauma?
該頭部創傷有否導致神經系統後遺症?

☐ Yes, please provide specify the exact symptoms and the type(s) of the limitation(s) ☐ No 沒有
有，請提供確實的徵狀及限制類型之詳情 :

(b) Is that sequelae permanent?
該神經系統後遺症是否永久性?
☐, please provide details : ☐ No不是
是，請詳述 :

(c) Was there any permanent neurological deficit / functional impairment manifested?
有否證實病人出現了持久性神經系統缺陷或功能損害?

☐ Yes, please describe the type(s) and the severity of neurological deficit / functional impairment: ☐ No 沒有
有，請詳述神經系統缺陷或功能損害的類型及嚴重程度:

13. What is the score of the patient on the Glasgow Outcome Scale of Head Injuries in this head trauma incident?
病人在這次頭部創傷的格拉斯哥之頭部損傷結果尺度是多少?

14. 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)

Test Date (DD/MM/YY) 檢驗日期(日/月/年) Test Item 檢驗項目 Result / Diagnosis 結果/ 診斷

15. Is the disease diagnosed to be directly or indirectly caused by or result from 診斷病症是否直接或間接由下列引起或導致
☐ self-inflicted injuries while sane or insane 在神志正常或失常的情況下蓄意自殘
☐ Wilful misuse of any alcohol,narcotic or drug 酗酒，濫用葯物或毒品

Please give details if any of the above item(s) is/are applicable. 如上述適用者， 請提供詳情

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 Physician _____ Qualification _____
醫生姓名 資歷
Hospital Name (if applicable) _____ Telephone No. _____
醫院名稱(如適用) 聯絡電話
Address _____
地址
Signature & Hospital/ Physician's Chop _____ Date (DD/MM/YY) _____
醫院/ 醫生簽署及蓋印 日期 (日/月/年)