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 :

Motor Neurone Disease
Unequivocal diagnosis of Motor Neurone Disease by a specialist neurologist supported by definitive evidence of appropriate and relevant neurological signs.

運動神經元病
由神經專科醫生明確診斷爲患上運動神經元病，而且有適當及相關的神經病徵狀作爲決定性的證明

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 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**?

☐ Yes, |_____|_____|_____| (DD/MM/YY) By (name & address of physician): _____ ☐ 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 ?
☐ 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

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

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

12. (a) How would you describe the patient's current medical condition? 請描述病人現時的健康狀況

(b) Please describe the relevant neurological signs presented by the patient that related to motor neurone disease and state the definitive evidence.
請描述病人與運動神經元病相關的神經病徵狀及決定性的證明

13. (a) What is the occupation of this patient? 病人的職業是什麼?

(b) With respect to the patient's occupation and duties, how would it be affected by this illness? 根據病人的職業及職務，此病如何影響病人?

(c) Would you consider the patient to be disabled? 閣下認爲病人是傷殘嗎?

☐ Yes, totally disabled from original occupation 是，完全無法進行其原來職業
☐ Yes, totally disabled from any occupation 是，完全無法進行任何職業
☐ Yes, partially disabled from original occupation 是，只能進行部分其原來職業
☐ Yes, partialy disabled from any occupation 是，只能進行部分任何職業
☐ No 不是

14. Please list the type(s) of treatments and medications that you have prescribed to the patient for this illness. 請詳述就此疾病給予病人的治療及藥物治療

Treatment / Name of Drug 治療/藥物名稱	Frequency / Dosage 頻率/劑量	Start Date (DD/MM/YY) 開始日期(日/月/年)	End Date (DD/MM/YY) 結束日期(日/月/年)

15. What tests / investigations 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 / Investigation Date (DD/MM/YY) 化驗/檢驗日期(日/月/年)	Test / Investigation Item 化驗/檢驗項目	Result / Diagnosis 結果/診斷

16. What is/are the underlying cause(s) leading to the motor neurone disease of this patient? 什麼原因引致病人的運動神經元病?

17. When did you last see the patient? What was his/her condition at that time? 請提供最近一次的診治日期以及病人當時的狀況

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

19. 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)