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 registerd, 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:

Stroke (Definition Before 2017)
Any cerebrovascular incident producing neurological sequelae lasting more than 24 hours and including infarction of brain tissue, haemorrhage and embolisation from an extra-cranial source. There must be evidence of permanent neurological deficit.

中風 (二零一七年前的定義)
任何腦血管病發事件，引起神經病後遺症持續超過24小時，包括腦組織梗塞、腦出血及源自頭顱外之栓塞，並且必須有永久性神經功能不足的證據。

Stroke (Definition from 2017 onwards)
Any cerebrovascular incident producing neurological sequelae lasting more than 24 hours and including infarction of brain tissue, haemorrhage and embolisation from an extra-cranial source.

This event must result in neurological functional impairment with objective neurological abnormal sign on physical examination by a Registered Specialist Neurologist at least 4 weeks after the event.

The following are excluded:
(a) Transient Ischemic Attack (TIA);
(b) brain damage due to migraine; and
(c) vascular disease affecting the eye, optic nerve or vestibular function.

中風 (二零一七年起的定義)
任何腦血管病發事件，引起神經系統後遺症持續超過24 小時，包括腦組織梗塞、腦出血及源自頭顱外之栓塞。

本項疾病必須導致神經功能性受損，發病後至少4個星期由註冊腦神經科專科醫生進行身體檢查，確認有客觀神經異常症狀。

以下情況不在受保之列：
a) 短暫性腦缺血發作（TIA）；
b) 由於偏頭痛而導致的腦損傷；及
c) 對眼或視覺神經或前庭系統功能造成影響的血管疾病。

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 dated 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 his/her illness(es)? 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) 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，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 clnical basis. 請提供所有診斷及臨床診斷的詳情

7. Was the patient refered 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. 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

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

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 ❒ No 沒有

❒ 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. Please describe the initial episode: 請描述初診情況:

(a) Nature of the episode 初診性質

(b) Date of the episode 初診日期 |_____|_____|_____| (DD/MM/YY) (日/月/年)

(c) Is this an acute attack? How long has the symptom lasted for? 是次中風是否急性病發? 其病徵持續了多久?

(d) Is there any infarction of brain tissue, haemorrhage embolisation from an extra-cranial source was resulted?
是否有腦組織梗塞、腦出血或源自頭顱外之栓塞的情況出現？

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

(e) Is cerebrovascular incident due to the following: 腦血管病發事件是否因以下:

(i) Transient Ischemic Attack (TIA) 短暫性腦缺血發作	❒ Yes 是	❒ No 不是
(ii) brain damage due to migraine 由於偏頭痛而導致的腦損傷	❒ Yes 是	❒ No 不是
(iii) vascular disease affecting the eye, optic nerve or vestibular function 對眼或視覺神經或前庭系統功能造成影響的血管疾病	❒ Yes 是	❒ No 不是

(f) Has any radiological scanning or imaging procedures on brain or other tests were performed? (Please enclose copies of all laboratory reports and any relevant hospital reports that are available.) 有否進行腦掃描等程序或其它檢驗? (請提交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 / Final Diagnosis 結果/ 最後診斷

12. (a) Any neurological sequelae which lasted more than 24 hours?
病人是否有出現超過持續二十四小時的神經系統後遺症?

❒ Yes, please provide full details on the neurological sequelae: ❒ No 沒有
有，請詳述後遺症的症狀:

(b) Are the neurological sequelae permanent?
該神經系統後遺症是否永久性的？

❒ Yes, please provide full details: 是，請詳述: ❒ No 不是

(c) Any neurological functional impairment with objective neurological abnormal sign on physical examination at least 4 weeks after the event ?
發病至少4個星期後，是否有進行身體檢查，確認有客觀神經異常症狀?

❒ Yes, please provide full details: 是，請詳述: ❒ No 沒有

(d) The patient's present limitations on both physical and mental conditions. 病人現時的體能和精神限制和狀況

(e) Date of return to normal activities. 回復正常活動的日期 |_____|_____|_____| (DD/MM/YY) (日/月/年)

13. Has the patient ever had history of stroke in the PAST and / or any history of related illness, heart problem, hypertension, diabetes mellitus, high blood cholesterol or obesity? 病人過往是否有中風及/或相關的病症、心臟疾病、高血壓、糖尿病、高膽固醇或肥胖的病史?

❒ Yes, please provide full 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

14. 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)