**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, 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:**

(1) **Early Stage Dementia including Early Stage Alzheimer's Disease**

Diagnosis of dementia based on neurological assessment by a Registered Specialist who who is a Registered Specialist Geriatrician, Registered Specialist Neurologist or Registered Specialist Psychiatrist confirming cognitive impairment characterised by a Mini Mental State Examination score of 19 or less out of 30, or equivalent score on another medically validated and accepted test of cognitive function. In order to satisfy the definition, two confirmatory neuropsychometric tests performed at least six months apart are required, and both of the assessments should be based on the same neuropsychometric test and meet the required level of severity. The Life Assured must have been placed on disease modifying treatment prescribed by the Registered Specialist and must be under the continuous care of the Registered Specialist.

**早期腦退化症(包括早期阿耳滋海默氏症)**

經註冊專科醫生（必須為老年病專科醫生、腦神經科專科醫生或精神科專科醫生）透過神經系統評估診斷為腦退化症，確認有認知功能障礙，即30分為滿分的簡短智能測只有19分或以下，或其他醫學上驗證及接受的認知功能測試達相同評級。為符合本定義，兩次神經精神學測試必須相隔最少6個月進行，而且兩次必須為相同的神經精神學測試及符合所需嚴重程度。受保人必須已經由該註冊專科醫生處方接受改善病情治療，並且必須一直由該註冊專科醫生護理。

(2) **Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders (Dementia)**

Progressive deterioration or loss of intellectual capacity or abnormal behaviour as evidenced by the clinical state and accepted standardised questionnaires or tests arising from Alzheimer's Disease or irreversible organic degenerative disorders resulting in significant reduction in mental and social functioning requiring the continuous supervision of the Life Assured. The diagnosis must be confirmed by a Registered SpecialistGeriatrician, Registered Specialist Neurologist or Registered Specialist Psychiatrist.

Alzheimer's disease or other dementia caused by psychiatric illness, any drug or alcohol use or any reversible organic brain disorder is excluded.

**阿耳滋海默氏症/不可還原之器質性腦退化疾病（腦退化症）**

根據臨床狀態及認可的標準問卷或測試證實因患上阿耳滋海默氏症（腦退化性疾病）引起的智力漸進式衰退、喪失或行為異常，或不可復原的機能退化失調而導致精神及社交功能明顯減退，使受保人需要持續接受照料。必須由註冊老年病專科醫生，註冊腦神經科專科醫生或註冊精神科專科醫生證實。

精神病、任何藥物或酒精引起的阿耳滋海默氏症/不可還原之器質性腦退化疾病及可還原的器質性腦疾病概不受保。

(3) Severe Dementia (*for Annuity Benefit):

"Severe Dementia" means Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders (Dementia) characterised by a Mini Mental State Examination score of 10 or less out of 30, or equivalent score on another medically validated and accepted test of cognitive function.

**嚴重腦退化症 (*終身年金)**

「嚴重腦退化症」是指阿耳滋海默氏症/不可還原之器質腦退化性疾病（腦退化症），並須在30分為滿分的簡短智能測驗（MMSE）中取得10分或以下或在另一項經醫學驗證和認可的認知功能測試中取得同等分數。

| 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 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. Has the patient ever been treated for the same/related conditions?

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

| 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. All medical consultants, physicians (general physicians or 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 |
|---|---|---|---|

10. What assessment tests were performed to confirm the patient's diagnosis of Alzheimer's Disease or irreversible organic degenerative disorders? (Please provide a copy of all test reports)
已進行什麼評估測試確定病人診斷為阿爾茲海默氏症或不可復原的機能退化失調？(請提供檢驗報告及醫療報告副本)

❒ Mini Mental State Examination(MMSE):《簡易智慧量表(MMSE)》

Assessment Test Date (DD/MM/YY) 評估測試日期 日/月/年 (MMSE) Assessment Score_____ 《簡易智慧量表》評估分數

❒ Other medically validated and accepted test of cognitive function test / questionnaire:

| Name of Assessment Test / questionnaire 評估測試/問卷名稱 | Assessment Test / questionnaire Date (DD/MM/YY) 評估測試/問卷日期 日/月/年 | Result / Score_____ 測試結果 / 分數 |
|---|---|---|

❒ Have not performed any assessment test / questionnaire 沒有進行任何評估測試/問卷

11. What kinds of the clinical evidence, questionnaires and lor tests have been performed to confirm the patient's Alzheimer's Disease or irreversible organic degenerative disorders? (Please provide details and the tests and/ or questionnaires for the diagnosis of the patient's Alzheimer's Disease or dementia)

有什麼臨床的證據、問卷及/或測試以確定病人的阿爾茲海默氏症或不可復原的機能退化失調?
(請提供有關確定病人之阿爾茲海默氏症或癡呆的檢驗及/或問卷的詳情)

| Test / Questionnaire Date (DD/MM/YY) 檢驗/問卷日期 (日/月/年) | Test Item / Questionnaire 檢驗項目/ 問卷 | Result / Diagnosis 結果/ 診斷 |
|---|---|---|

12. Please describe the severity of the condition and specify impact(s) on the patient's daily activities with respect of the following areas.

請詳述病人以下狀態的程度及對其日常活動的影響。

(a) Loss of intellectual capacity 智力衰退
(b) Reduction in mental and social functioning 精神及社交功能減退
(c) Need for continuous supervision 接受持續照料的需要

13. Does the patient require continuous supervision?

病人是否需要持續接受照料？

❒ Yes, please advise what kinds of continuous supervision were provided and the details.

是，請詳述病人需要那一類型的照料。

❒ No, please advise why no continuous supervisions required
不是，請詳述病人為何不需要持續接受照料？

14. Is the patient 's Alzheimer's Disease or dementia related to and / or caused by neurosis, psychiatric illness?
病人的阿爾茲海默氏症或癡呆是否興神話官能布或精神病有關或由神經官能有或精神病導致？

❒ Yes, please provide details of the aforesaid condition with (a) first consultation date, and (b) name and address of the medical attendant(s):
是，請詳述以上情況，包括(a)初次求診日期及(b) 醫生姓名及地址

❒ No 否

15. What tests were performed to confirm the diagnosis and progress of the disease.? (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及進展? (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 | Test Item 檢驗項目 | Result / Histopathological Diagnosis 結果/ 診斷 |
|---|---|---|

16. What is the prognosis Of the patient?

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

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

Address_____
地址

Signature & Hospital/ Physician's Chop _____
醫院/ 醫生簽署及蓋印

Qualification _____
專業資格

Telephone No. _____
電話號碼

Date (DD/MM/YY) _____
日期 (日/月/年)