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:

Brain Surgery (Definition before 2005)
The actual undergoing of surgery to the brain under general anaesthesia.
Brain surgery as a result of an accident is excluded. The procedure must be considered necessary by a qualified specialist.

腦部外科手術(二零零五年前的定義)
在全身麻醉下進行腦部外科手術。
因意外而需要進行的腦部外科手術除外。有關手術必須獲合資格的專科醫生認為必須進行。

Brain Surgery (Definition from 2005 onwards and before 2017)
The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy is performed. Keyhole surgery is included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolizations, thrombolysis and stereotactic biopsy are excluded. Brain surgery as a result of an Accident is also excluded. The procedure must be considered necessary by a Registered Specialist in the relevant field.

腦部外科手術(二零零五年起至二零一七年前的定義)
在全身麻醉下進行腦部顱骨切開手術。腦部外科手術包括鎖孔外科手術但不包括所有不需手術切開或切除組織的治療如加碼射線、腦血管神經放射介入治療如栓塞形成、血栓溶解及立體定位活檢。 因意外而需要進行的腦部外科手術亦同時除外。有關手術必須獲合資格的專科醫生認為必須進行。

Brain Surgery (Definition from 2017 onwards)
The actual undergoing of surgery to the brain via the skull or cranium under general anaesthesia during which a craniotomy is performed. Burr hole surgery is included. However, the followings are excluded,
a) minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolization, thrombolysis and stereotactic biopsy;
b) transphenoidal surgery; and
c) brain surgery as a result of an Accident.
The procedure must be considered to be Medically Necessary by a Registered Specialist in the relevant field.

腦部外科手術 (二零一七年起的定義)
在全身麻醉下進行經頭顱的顱骨切開術作腦部手術。腦部外科手術包括顱骨鑽孔術，惟以下情況概不受保：
a) 不需手術切開或切除組織的治療如伽瑪射線、腦血管神經放射介入治療如栓塞形成、血栓溶解及立體定位活檢；
b) 經蝶竇手術；及
c) 因意外而需要進行的腦部外科手術。
有關手術必須獲相關醫學範疇的註冊專科醫生認為屬醫療需要。

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 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) 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 從 |_____|_____|_____| (DD/MM/YY) (日/月/年) OR 或 For 已存在 _____day(s) 日 _____ month(s) 月 _____year(s) 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) 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) (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? 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 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 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

❒ 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. 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

12. (a) Name, date and details of the brain surgery performed.
請提供該腦部外科手術的名稱，進行日期及詳情。

(b) Is general anaesthesia used during the brain surgery? What was the reason?
該腦部外科手術是否在全身麻醉下進行？請說明理由。

☐ Yes 是 ☐ No不是

(c) Did the surgery performed involve any of the following surgery? 該腦部手術是否與以下手術一併進行?

(i) Craniotomy 經頭顱的顱骨切開術	☐Yes 是	☐No 不是
(ii) Burr hole surgery 顱骨鑽孔術	☐Yes 是	☐No 不是
(iii) Transphenoidal surgery 經蝶竇手術	☐Yes 是	☐No 不是
(iv) Minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolization, thrombolysis and stereotactic biopsy **Please circle the applicable 不需手術切開或切除組織的治療如伽瑪射線、腦血管神經放射介入治療如栓塞形成、血栓溶解及立體定位活檢 **請圈出手術名稱	☐Yes 是	☐No 不是

13. Is the brain surgery required as a result of any event of accident?
該腦部外科手術是否因為意外而需要進行？

☐ Yes, details of the accident are:
是，意外的詳情是：

☐ No, the underlying cause(s) leading to this brain surgery is/are:
不是，導致進行此腦部外科手術的原因是：

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

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

16. 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)