

## 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? <input type="checkbox"/> Yes, medical records date back to 是, 醫療紀錄可溯至 _____ (DD/MM/YY) 日/月/年 <input type="checkbox"/> 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? <input type="checkbox"/> Yes, _____ (DD/MM/YY) By (name & address of physician): _____ <input type="checkbox"/> 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? <input type="checkbox"/> Yes, please provide details: 有, 請詳述: _____ <input type="checkbox"/> No 沒有 <table border="0"> <tr> <td><u>Consultation Dates</u> (DD/MM/YY)</td> <td><u>Physician / Hospital</u></td> <td><u>Diagnosis</u></td> <td><u>Treatment and Investigation Results / Hospitalization</u></td> </tr> <tr> <td>就診日期 日/月/年</td> <td>醫生/ 醫院全名</td> <td>診斷</td> <td>任何醫療診治及檢查結果 / 住院詳情</td> </tr> </table>			<u>Consultation Dates</u> (DD/MM/YY)	<u>Physician / Hospital</u>	<u>Diagnosis</u>	<u>Treatment and Investigation Results / Hospitalization</u>	就診日期 日/月/年	醫生/ 醫院全名	診斷	任何醫療診治及檢查結果 / 住院詳情
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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? <input type="checkbox"/> Yes, please provide details: 有, 請詳述: _____ <input type="checkbox"/> No 沒有										
8. Does the patient smoke cigarette? 病人是否有吸煙習慣? <input type="checkbox"/> Yes, has been smoking since 有, 由 _____ (DD/MM/YY) 日/月/年 開始吸煙 <input type="checkbox"/> No 沒有 <input type="checkbox"/> 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 <table border="0"> <tr> <td><u>Consultation Date</u> (DD/MM/YY)</td> <td><u>Physician / Hospital</u></td> <td><u>Diagnosis</u></td> <td><u>Treatment and Investigation Results / Hospitalization</u></td> </tr> <tr> <td>就診日期 日/月/年</td> <td>醫生/ 醫院全名</td> <td>診斷</td> <td>任何醫療診治及檢查結果 / 住院詳情</td> </tr> </table>			<u>Consultation Date</u> (DD/MM/YY)	<u>Physician / Hospital</u>	<u>Diagnosis</u>	<u>Treatment and Investigation Results / Hospitalization</u>	就診日期 日/月/年	醫生/ 醫院全名	診斷	任何醫療診治及檢查結果 / 住院詳情
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10.	<p><b>Please provide the full details of the accident leading to head trauma.</b> 請提供導致該頭部創傷的意外詳情</p> <p>(a) <b>Date &amp; Time</b> 日期及時間</p> <p>(b) <b>Location</b> 地點</p> <p>(c) <b>Where and how did it happen? (Describe activities engaged if applicable)</b> 意外如何發生及事發地點 (如適用, 請形容當時進行之活動)</p>							
11.	<p><b>Is there any residual brain damage resulting from the head trauma?</b> 該頭部創傷有否導致殘餘腦部損傷? Please provide details : 有, 請詳述 :</p>	<input type="checkbox"/> No 沒有						
12.	<p>(a) <b>Is there any neurological sequelae resulting from the head trauma?</b> 該頭部創傷有否導致神經系統後遺症?</p> <p><input type="checkbox"/> Yes, please provide specify the exact symptoms and the type(s) of the limitation(s) 有, 請提供確實的徵狀及限制類型之詳情 :</p> <p>(b) <b>Is that sequelae permanent?</b> 該神經系統後遺症是否永久性? , please provide details : 是, 請詳述 :</p> <p>(c) <b>Was there any permanent neurological deficit / functional impairment manifested?</b> 有否證實病人出現了持久性神經系統缺陷或功能損害?</p> <p><input type="checkbox"/> Yes, please describe the type(s) and the severity of neurological deficit / functional impairment: 有, 請詳述神經系統缺陷或功能損害的類型及嚴重程度:</p>	<p><input type="checkbox"/> No 沒有</p> <p><input type="checkbox"/> No 不是</p> <p><input type="checkbox"/> No 沒有</p>						
13.	<p><b>What is the score of the patient on the Glasgow Outcome Scale of Head Injuries in this head trauma incident?</b> 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?</p>							
14.	<p><b>What tests were performed to confirm the diagnosis? (Please enclose copies of all laboratory reports and relevant medical reports that are available)</b> 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)</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>Test Date (DD/MM/YY)</u> 檢驗日期(日/月/年)</th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Test Item</u> 檢驗項目</th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Result / Diagnosis</u> 結果/ 診斷</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"> </td> <td> </td> <td> </td> </tr> </tbody> </table>	<u>Test Date (DD/MM/YY)</u> 檢驗日期(日/月/年)	<u>Test Item</u> 檢驗項目	<u>Result / Diagnosis</u> 結果/ 診斷				
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15.	<p><b>Is the disease diagnosed to be directly or indirectly caused by or result from</b> 診斷病症是否直接或間接由下列引起或導致</p> <p><input type="checkbox"/> self-inflicted injuries while sane or insane 在神志正常或失常的情況下蓄意自殘</p> <p><input type="checkbox"/> Wilful misuse of any alcohol, narcotic or drug 酗酒, 濫用藥物或毒品</p> <p>Please give details if any of the above item(s) is/are applicable. 如上述適用者, 請提供詳情</p>							
16.	<p><b>What is the prognosis of the patient?</b> 病人現時進展及狀況</p>							
17.	<p><b>Other additional information for the current diagnosis</b> 其他有關此診斷結果之額外資料</p>							
<p>Name of Physician _____ 醫生姓名</p> <p>Hospital Name (if applicable) _____ 醫院名稱(如適用)</p> <p>Address _____ 地址</p> <p>Signature &amp; Hospital/ Physician's Chop _____ 醫院/ 醫生簽署及蓋印</p>		<p>Qualification _____ 資歷</p> <p>Telephone No. _____ 聯絡電話</p> <p>Date (DD/MM/YY) _____ 日期 (日/月/年)</p>						

