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:

Multiple Sclerosis (Definition Before 2017)

Unequivocal diagnosis by a Registered Specialist Neurologist and confirmed by modern investigational techniques such as image scanning confirming more than one episode of well-defined neurological symptoms, with persisting signs or involvement of the optic nerves, brain stem and spinal cord together with impairment of co-ordination and motor and sensory function, with the Life Assured not necessarily confined to a wheel chair.

多發性硬化症 (二零一七年前的定義)

由註冊腦神經科專科醫生明確診斷，並經過影像掃描等現代化診症技術核實，出現多於1 次明顯的神經科徵狀，持續出現或涉及視覺神經、腦幹及脊柱方面的症狀，並且有身體協調及運動、感官功能受損，但受保人不一定需要受困於輪椅。

Multiple Sclerosis (Definition from 2017 onwards)

Unequivocal diagnosis of Multiple Sclerosis by a Registered Specialist Neurologist, and which confirms the following:
• objective clinical evidence of ≥1 T2 lesion in at least 2 out of 4 regions of the central nervous system as mentioned below:
(i) Periventricular;
(ii) Juxtacortical;
(iii) Infratentorial;
(iv) spinal cord;
and
• more than one episode of well-defined neurological symptoms involving the optic nerves, brain stem, spinal cord, coordination or motor function; and
• a well-documented history of exacerbations and remissions of neurological symptoms over a period of more than 6 months.

多發性硬化症 (二零一七年起的定義)

由註冊腦神經科專科醫生明確診斷為多發性硬化症，並確定下列各項：
• 以下四個中樞神經系統區域中最少兩個區域有≥ 1個T2病變的客觀臨床證據：
(i) 腦室周圍；
(ii) 近腦皮質；
(iii) 小腦幕下；
(iv) 脊髓；
及
• 出現多於1次明顯的神經科徵狀，涉及視覺神經、腦幹、脊髓、身體協調或運動功能；及
• 對神經科徵狀的病徵有六個月以上詳細的病歷記錄，包括病情變壞及復原的病史。

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 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) 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 referred 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? 病人是否曾經接受相同 / 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 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

❒ 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. Does the patient has the following condition?
病人是否有以下的狀況?

objective clinical evidence of ≥1 T2 lesion in at least 2 out of 4 regions of the central nervous system as mentioned below
以下四個中樞神經系統區域中最少兩個區域有≥ 1個T2病變的客觀臨床證據

❒ Yes 有 ❒ No 沒有 Periventricular 腦室周圍
❒ Yes 有 ❒ No 沒有 Juxtacortical 近腦皮質
❒ Yes 有 ❒ No 沒有 Infratentorial 小腦幕下
❒ Yes 有 ❒ No 沒有 spinal cord 脊髓

more than one episode of well-defined neurological symptoms
出現多於1次明顯的神經科徵狀，涉及視覺神經、腦幹、脊髓、身體協調或

❒ Yes 有 ❒ No 沒有 optic nerves 視覺神經；
❒ Yes 有 ❒ No 沒有 brain stem腦幹；
❒ Yes 有 ❒ No 沒有 spinal cord脊髓；
❒ Yes 有 ❒ No 沒有 coordination 身體協調；
❒ Yes 有 ❒ No 沒有 motor function 運動功能；

a well-documented history of exacerbations and remissions of neurological symptoms over a period of more than 6 months.
對神經科徵狀的病徵有六個月以上詳細的病歷記錄，包括病情變壞及復原的病史。

❒ Yes 有 Please provide all the medical records 請提供所有病歷記錄 ❒ No 沒有

13. Is there any impairment of co-ordination and motor and sensory function？
病人的身體協調及運動、感官功能有否受損？

❒ Yes, please provide details. 有，請詳述其程度。 ❒ No 沒有

14. Was there a history of repeated relapse and remission of steady progressive disability?
病人的漸進式殘疾有否重複出現復發及緩解的病史？

❒ Yes, please provide details. 有，請詳述其程度。 ❒ No 沒有

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	Diagnosis/ Result 診斷/ 結果

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

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

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)