**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 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 :**

**Muscular Dystrophy**
Hereditary muscular dystrophy confirmed by a specialist neurologist resulting in the inability to perform without assistance 3 or more of the following:
- bathing, dressing, using the lavatory, eating, moving in or out of a bed or chair.

**肌營養不良**
由神經專科醫生證實爲遺傳性肌營養不良，導致在沒有協助的情況下無法完成下列3項或以上的活動：洗澡、穿衣、如廁、進食、離開或返回床或椅子。

| 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 date 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 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. (a) Clinical diagnosis 臨床診斷

(b) When was it made? 何時確實這診斷? |_____|_____|_____| (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) By (name & address of physician): _____
日/月/年 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: 最後診斷日期 |_____|_____|_____| (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) By (name & address of physician): _____
日/月/年 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, |_____|_____|_____| (DD/MM/YY) By (name & address of physician): _____ ☐ No 不是
是， 日/月/年 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 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 |
|---|---|---|---|
| | | | |

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 ☐ No 沒有

☐ 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

11. 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

| 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. What type of muscular dystrophy does the patient has? 病人的肌營養不良屬於那一類型?

13. What is/are the underlying cause(s) leading to the muscular dystrophy of this patient? 什麼原因引致病人的肌營養不良?

14. (a) Is the patient able to perform any of the followings without assistance? 病人在沒有協助的情況下有否進行下列活動的能力?
(b) Please state **since when**, **why and how much assistance is required** if the patient is **unable to perform.**
如病人**不能夠進行**下列活動，請列明**從何時開始、原因**及**所需要的協助**

| | | |
|---|---|---|
| (i) Bathing 洗澡 | ☐ Able 能夠 | ☐ Unable 不能夠<br>Reason 原因:<br>Asistance required 所需要的協助:<br>Since 自從: |
| (ii) Dressing 穿衣 | ☐ Able 能夠 | ☐ Unable 不能夠<br>Reason 原因:<br>Asistance required 所需要的協助:<br>Since 自從: |
| (iii) Using the lavatory 如廁 | ☐ Able 能夠 | ☐ Unable 不能夠<br>Reason 原因:<br>Asistance required 所需要的協助:<br>Since 自從: |
| (iv) Eating 進食 | ☐ Able 能夠 | ☐ Unable 不能夠<br>Reason 原因:<br>Asistance required 所需要的協助:<br>Since 自從: |
| (v) Move in or out of a bed or chair 離開或返回床或椅子 | ☐ Able 能夠 | ☐ Unable 不能夠<br>Reason 原因:<br>Asistance required 所需要的協助:<br>Since 自從: |

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 / Diagnosis 結果/ 診斷 |
|---|---|---|
| | | |

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 Physician _____ Qualification _____
醫生姓名 資歷
Hospital Name (if applicable) _____ Telephone No _____
醫院名稱(如適用) 聯絡電話
Address _____
地址
Signature & Hospital/ Physician's Chop _____ Date (DD/MM/YY) _____
醫院/ 醫生簽署及蓋印 日期 (日/月/年)