

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 :

Occupationally Acquired HIV

Infection with HIV where it was acquired as a result of an accident during the course of carrying out normal occupational duties with sero-conversion to Positive HIV antibody occurring within 6 months of the accident. Any accident giving rise to a potential claim must be reported to us within 30 days of the incident and be supported by a negative HIV antibody test taken immediately after the incident. This coverage shall cease in the event of an efficient and effective vaccine being found for the prevention of HIV/AIDS.

Your benefit does not cover sexually transmitted HIV infection.

因職業感染人類免疫缺陷病毒

指在執行正常職務中，因意外受感染人類免疫缺陷病毒，並於意外發生起計6個月內，對人類免疫缺陷病毒抗體出現血清轉化為陽性。任何可能促成索償的意外，必須於發生起計30日內向本公司報告，並提供於意外後立刻進行的人類免疫缺陷病毒抗體陰性測試結果。假如研製出有效率及有效用的人類免疫缺陷病毒／愛滋病疫苗，本保障將終止。

閣下的保障不包括經由性接觸傳播的人類免疫缺陷病毒感染。

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 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? <input type="checkbox"/> Yes, _____ (DD/MM/YY) By (name & address of physician): _____ 是, _____ 日/月/年 由 (醫生姓名及地址): _____ <input type="checkbox"/> No 不是		



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:

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

No 沒有

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. Was the infection of Human Immune-deficiency Virus due to an accident during the course of work?
病人是否在工作期間因意外感染人類免疫缺陷病毒?

Yes, Details: 是, 請詳述:

(a) When did the accident happen? 意外在何時發生?

On _____ (DD/MM/YY)
於 _____ (日/月/年)

(b) Where did the accident happen? 意外在何處發生?

(c) How did the accident happen? 意外如何發生?

(d) How did you confirm that the aforesaid infection was due to an accident during the course of work?
閣下如何確定該感染是在工作期間因意外感染?

No. Is the HIV infection of this patient related to any sexual activity or intravenous drug use?
不是。病人是否因性行為或經由靜脈注射藥物而感染人類免疫缺陷病毒?

Yes, Details: 是, 請詳述

No 不是

13. (a) When did the patient take the **FIRST** blood test after the accident? What was its result?

病人於意外後**首次**檢驗的日期及結果

On _____ (DD/MM/YY), Result:
於 _____ (日/月/年), 結果:

(b) After the **FIRST** HIV antibody blood test, was there any additional test(s) performed?
於**首次**人類免疫缺陷病毒檢驗後, 有否進行額外的檢驗?

Yes, please provide date(s) of the further HIV antibody blood test(s) and the result(s)
有, 請提供進一步的人類免疫缺陷病毒抗體的檢驗及結果:

No 沒有

Test Date (DD/MM/YY) 檢驗日期(日/月/年)

Test Item 檢驗項目

Result 結果



14. 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

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

16. Other additional information for the current diagnosis 其他有關此診斷結果之額外資料

Name of Physician _____
醫生姓名

Qualification _____
資歷

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

Telephone No. _____
聯絡電話

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)

