

## 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 :

<p><b>Parkinson's Disease</b> Slowly progressive degenerative disease of the central nervous system as a result of loss of pigment containing neurones of the brain. Unequivocal diagnosis of Parkinson's Disease by a specialist neurologist where the condition:</p> <p><input type="checkbox"/> cannot be controlled with medication; and  <input type="checkbox"/> shows signs of progressive impairment; and  <input type="checkbox"/> inability of the Life Assured to perform 3 or more of the following – bathing, dressing, using the lavatory, eating, moving in or out of a bed or chair.  Only idiopathic Parkinson's Disease is covered. Your benefit does not cover any other forms of Parkinsonism.</p> <p><b>柏金遜病</b> 因失去含色素腦神經細胞而引致的中樞神經系統緩慢地漸進式退化性疾。由神經專科醫生明確診斷為柏金遜病，並符合以下條件：  <input type="checkbox"/> 無法以藥物控制；及  <input type="checkbox"/> 出現漸進性障礙的徵狀；及  <input type="checkbox"/> 受保人無法進行下列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。  閣下的保障只包括原發性柏金遜病，而不包括其他形式的柏金遜病。</p>
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Name of Patient 病人姓名	ID / Passport No. 身份證 / 護照號碼	Age & Sex 年齡及性別								
<p>1. Are you the patient's usual physician? 你是否病人慣常求診的醫生?</p> <p><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</p>										
<p>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?</p> <p>_____ (DD/MM/YY) 日/月/年 Symptoms presented were: 病徵包括: _____</p>										
<p>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?</p> <p>Since _____ (DD/MM/YY) OR for _____ day(s) _____ month(s) _____ year(s) 從 _____ 日/月/年 或 已存在 _____ 日 _____ 月 _____ 年</p>										
<p>4. (a) Clinical diagnosis 臨床診斷</p> <p>(b) When was it made? 何時確實這診斷? _____ (DD/MM/YY) 日/月/年</p> <p>(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 &amp; address of physician): _____ 日/月/年 由 (醫生姓名及地址)</p> <p>(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? _____</p>										
<p>5. (a) Final diagnosis 最後診斷</p> <p>(b) Date of final diagnosis: 最後診斷日期 _____ (DD/MM/YY) 日/月/年</p> <p>(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 &amp; address of physician): _____ 日/月/年 由 (醫生姓名及地址):</p>										
<p>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</p>										
<p>7. Was the patient referred to you from other physician(s)? 病人是否由其他醫生轉介?</p> <p><input type="checkbox"/> Yes, _____ (DD/MM/YY) By (name &amp; address of physician): _____ <input type="checkbox"/> No 不是 是， _____ 日/月/年 由 (醫生姓名及地址):</p>										
<p>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?</p> <p><input type="checkbox"/> Yes, please provide details: 有，請詳述: <input type="checkbox"/> No 沒有</p> <table border="1"> <thead> <tr> <th>Consultation Dates (DD/MM/YY) 就診日期</th> <th>Physician / Hospital 醫生/ 醫院全名</th> <th>Diagnosis 診斷</th> <th>Treatment and Investigation Results / Hospitalization 任何醫療診治及檢查結果 / 住院詳情</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>			Consultation Dates (DD/MM/YY) 就診日期	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				
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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, 或被轉介過的所有醫生 (普通科及專科) 和醫院的名稱

<u>Consultation Date (DD/MM/YY)</u>	<u>Physician / Hospital</u>	<u>Diagnosis</u>	<u>Treatment and Investigation Results / Hospitalization</u>
就診日期	醫生/ 醫院全名	診斷	任何醫療診治及檢查結果 / 住院詳情

12. Is the Parkinson's Disease idiopathic in nature? 病人的帕金森是否原發性病性?  
 Yes, reason: 是, 原因為:  
  
  
  
  
  
  
  
  
  
 No 不是, 原因為:

13. Can the Parkinson's Disease be controlled with medication? 病人的帕金森可否以藥物控制?  
 Yes, please provide details : 可以, 請詳述  No 不可以

14. Does it show sign of progressive impairment? Please support with laboratory/ test reports  
 病人有否出現漸進性障礙的徵狀? (請提供有關化驗/檢驗報告)  
 Yes, please provide details : 有, 請詳述  No 沒有



15. (a) Is the patient able to perform any of the followings? 病人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

Reason 原因:

Asistance required 所需要的協助:

Since 自從:

(ii) Dressing  
穿衣

Able 能夠

Unable 不能夠

Reason 原因:

Asistance required 所需要的協助:

Since 自從:

(iii) Using the lavatory  
如廁

Able 能夠

Unable 不能夠

Reason 原因:

Asistance required 所需要的協助:

Since 自從:

(iv) Eating  
進食

Able 能夠

Unable 不能夠

Reason 原因:

Asistance required 所需要的協助:

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

Reason 原因:

Asistance required 所需要的協助:

Since 自從:

(d) Please provide details of clinical signs that were present when the patient first consulted you for this condition. 請詳述病人於首次求診時的臨床病徵。

16. 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 / Histopathological Diagnosis 結果/ 病理組織診斷

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

18. 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

Hospital Name (if applicable) \_\_\_\_\_

醫院名稱(如適用)

Address \_\_\_\_\_

地址

Signature & Hospital/ Physician's Chop \_\_\_\_\_

醫院/ 醫生簽署及蓋印

Qualification \_\_\_\_\_

資歷

Telephone No. \_\_\_\_\_

聯絡電話

Date (DD/MM/YY) \_\_\_\_\_

日期(日/月/年)

