

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 :

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| <p>Severance of Limbs The irreversible severance of two or more limbs where severance is above the elbow or the knee.</p> <p>肢體切斷 兩肢或以上不可復原地切斷，切斷須在手肘或膝蓋以上。</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 & 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 & 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 & 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="0" style="width:100%"> <tr> <td style="width:25%"><u>Consultation Dates</u> (DD/MM/YY) 就診日期 日/月/年</td> <td style="width:25%"><u>Physician / Hospital</u> 醫生/ 醫院全名</td> <td style="width:25%"><u>Diagnosis</u> 診斷</td> <td style="width:25%"><u>Treatment and Investigation Results / Hospitalization</u> 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) 就診日期 日/月/年 | <u>Physician / Hospital</u> 醫生/ 醫院全名 | <u>Diagnosis</u> 診斷 | <u>Treatment and Investigation Results / Hospitalization</u> 任何醫療診治及檢查結果 / 住院詳情 |
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| <p>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?</p> <p><input type="checkbox"/> Yes, please provide details: 有，請詳述: _____ <input type="checkbox"/> No 沒有</p> | | | | | | |



| <p>10. Does the patient smoke cigarette? 病人是否有吸煙習慣?</p> <p><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</p> <p><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</p> | | | | | | | | | |
|---|---|--|---|--------------------------|---|--|--|--|--|
| <p>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</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Consultation Date (DD/MM/YY) 就診日期 日/月/年</th> <th style="text-align: left; border-bottom: 1px solid black;">Physician / Hospital 醫生/ 醫院全名</th> <th style="text-align: left; border-bottom: 1px solid black;">Diagnosis 診斷</th> <th style="text-align: left; border-bottom: 1px solid black;">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 style="height: 40px;"> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table> | | 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 | | | | |
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| <p>12. What is/are the underlying cause(s) of the severance of limbs? 什麼原因引致的病人的肢體切斷?</p> | | | | | | | | | |
| <p>13. (a) Where is the site of the severance? 何處肢體被切斷?</p> <p>(b) Is the severance above the elbow or the knee? 被切斷的部分是否手肘或膝蓋以上?</p> <p><input type="checkbox"/> Yes, please provide details : <input type="checkbox"/> No 沒有 有, 請詳述 :</p> | | | | | | | | | |
| <p>14. Is the severance of limb(s) irreversible? (Please enclose copies of all supportive reports and relevant medical reports that are available). 病人的肢體切斷是否不可復原? (請提供有關檢驗報告及醫療報告副本)</p> <p><input type="checkbox"/> Yes, please provide details : 是, 請詳述 : <input type="checkbox"/> No 不是</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Test Date (DD/MM/YY) 檢驗日期(日/月/年)</th> <th style="text-align: left; border-bottom: 1px solid black;">Test Item 檢驗項目</th> <th style="text-align: left; border-bottom: 1px solid black;">Result / Diagnosis 結果/診斷</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"> </td> <td> </td> <td> </td> </tr> </tbody> </table> | | Test Date (DD/MM/YY) 檢驗日期(日/月/年) | Test Item 檢驗項目 | Result / Diagnosis 結果/診斷 | | | | | |
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| <p>15. Is there any other surgery/treatment helps to improve the patient's condition? 有否手術或治療可改善病人的情況?</p> <p><input type="checkbox"/> Yes, please provide details: <input type="checkbox"/> No 沒有 有, 請詳述:</p> | | | | | | | | | |
| <p>16. Is the disease diagnosed to be directly or indirectly caused by or result from 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> | | | | | | | | | |
| <p>17. What is the prognosis of the patient? 病人現時進展及狀況</p> | | | | | | | | | |
| <p>18. Other additional information for the current diagnosis 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 & 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> | | | | | | | | |

