

Accident Benefit Claim Form Part II – Attending Physician’s Statement
(To be completed by the registered medical practitioner at the Claimant’s expense)



意外保障賠償申請表第二部份 – 醫事報告 (由註冊醫生填寫, 所需費用由索償人支付)

		Policy No. _____
1. Name of Patient 病人姓名	2. Sex/Age 性別 / 年齡	3. ID / Passport no 身份証/護照號碼
4. (a) Are you the patient’s usual doctor? 閣下是否病人的慣常醫生? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes, since 是, 自 _____ (MM/YY 月/年)		
(b) Date of first consultation to you relating to this incident (DD/MM/YY) 病人首次就是次事故向閣下求診之日期 (日/月/年)		
(c) Signs and Symptoms at the consultation 求診時之病徵及病狀		
(d) Final Diagnosis 最後診斷		
5. (a) Date of accident (DD/MM/YY) 意外日期 (日/月/年)		
(b) Cause of accident 意外原因		
(c) Part of body injured 身體受傷之部位		
(d) Type and extent of injury 傷勢類別及程度		
(e) Is there any evidence of visible contusion, cut or wound at your first consultation? If “yes”, please describe in detail. 於首次求診時, 病人之傷勢有否呈現可見的挫傷、傷口或創傷? 如「有」, 請詳細列明。		
6. (a) Was the patient referred to you by another doctor? 病人是否經其他醫生轉介到閣下? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes, Name & Address of the referral doctor 是, 請提供轉介醫生姓名及地址		
(b) Did you refer the patient to other doctor or hospital? 閣下是否轉介該病人往其他醫生或醫院? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes, Name & Address of the doctor or hospital 是, 請提供醫生或醫院名稱及地址		
7. Type of diagnostic procedures, medication, treatment or operation required. (For example, x-ray, suturing, physiotherapy, etc.) 病人曾接受的診斷程序的類別、藥物、治療或手術 (如: X光、縫針、物理治療等)		
Date 日期	Investigation/ Result 檢查/ 結果	Medication/ Treatment/ Operation 藥物/治療/手術
8. Was the patient admitted into hospital? If “yes” please give details. 病人曾否入院? 如「是」, 請提供詳情。		
Name of Hospital 醫院名稱	Hospitalization Period 住院日期	Investigation / Surgery / Treatment 檢查/手術/治療

9. Subsequent consultations date and conditions 覆診日期及康復情況			
Date 日期	Conditions / Impairment 情況/身體缺陷	Treatment 治療	% of recovery 康復程度

10. (a) Has the patient reached maximum medical improvement?
病人是否已到達醫療上可復原的極限？ No 否 Yes 是

(b) What is the future treatment plan?
未來之治療計劃？

11. Were there any factors which may have contributed directly or indirectly to the accident or which may likely retard the recovery? If “yes”, please give details.
是否有任何因素直接或間接促成此意外或有可能防礙身體復原？如「是」，請提供詳情。

12. What is the occupation and job nature of the patient?
病人的職業及工作性質是什麼？

13. Total sick leave period granted for the injury 是次受傷而獲發之病假

From 由 _____ (DD/MM/YY日/月/年) to 至 _____ (DD/MM/YY日/月/年)

14. Please circle the following factors which is associated with the injury and provide details. 請圈出與是次受傷有關的下列因素並詳述。

Self-inflicted injury / Participating in any kind of hazardous sports / Alcoholic abuse / Drug abuse / Pregnancy / Illness / Physical defect or infirmity which existed prior to the incident / none of the above. 自致傷害 / 參與任何危險運動 / 濫用酒精 / 濫用藥物 / 懷孕 / 疾病 / 受傷前的身體缺陷或體弱 / 以上所列均不符合。

Details 詳情:

15. Other remarks 備註

I hereby certify that, having personally examined and treated the above-named patient for the above illness/injury, the facts as given above represent my opinion of his/her condition.
本人在此聲明，本人檢查及治療此病人之傷病，以上之所陳述乃本人對病人健康狀況之意見。

Signed 簽名:		Name of physician (with stamp) 醫生的姓名(蓋印):	
Qualifications 資歷:		Address 地址:	
Date 日期:		Telephone Number 電話號碼:	