

Attending Physician's Statement 醫事報告



Critical Illness – Stroke 危疾 – 中風

PART II - To be completed by doctor at Insured's/Claimant's expense (Chinese version is for reference only - English version shall prevail)

第二部份 – 由主診醫生填寫，所需費用由索償人承擔（中文版本只供參考，一切以英文版本為準）

Policy No. 保單號碼				
Name of Insured 受保人姓名	ID Card No. 身份證號碼	Age 年齡	Date of Birth 出生日期	Sex 性別

GENERAL INFORMATION 一般資料

<p>1. Are you the Insured's usual medical physician? 閣下是否受保人慣常求診之醫生？</p> <p><input type="checkbox"/> Yes, period of medical records extends from 是，醫療紀錄可追溯至 _____ (DD 日 / MM 月 / YY 年)</p> <p><input type="checkbox"/> No 否</p>																			
<p>2. When were you first consulted for this illness? 受保人何時首次就此病症向您求診？ _____ (DD 日 / MM 月 / YY 年)</p>																			
<p>3. What were the symptoms? 受保人求診時有何徵狀？</p>																			
<p>4. How long had the symptoms been present at that time? 徵狀當時已持續了多久？</p>																			
<p>5. Are you aware of whether the Insured had previously suffered from this illness or any related conditions? 受保人以往是否患有相同或類似病況？</p> <p><input type="checkbox"/> Yes 是</p> <p><input type="checkbox"/> No 否</p> <p>If "yes", please provide names, addresses and dates of doctors or facilities which the Insured has been referred and/or admitted to and the resulting diagnosis. 如「是」，請提供受保人就此病症求診之醫生或醫療機構名稱、地址及求診日期，及診斷結果。</p> <table border="1"> <thead> <tr> <th>Name of physician / facility 醫生 / 醫療機構名稱</th> <th>Address 地址</th> <th>Date of consultation / confinement period 求診 / 入住日期</th> <th>Diagnosis 診斷</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>				Name of physician / facility 醫生 / 醫療機構名稱	Address 地址	Date of consultation / confinement period 求診 / 入住日期	Diagnosis 診斷												
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<p>6. On which date was the diagnosis made? 病症確診日期 _____ (DD 日 / MM 月 / YY 年)</p>																			
<p>7. On which date was the Insured first made aware of it? 受保人知悉有關病症之日期 _____ (DD 日 / MM 月 / YY 年)</p>																			
<p>8. Is there anything in the Insured's family history which would have increased the risk of this illness? 受保人是否有親屬曾患相同或類似病症，或會增加受保人患病之機會？</p> <p><input type="checkbox"/> Yes, please provide details 是，請提供詳情 _____</p> <p><input type="checkbox"/> No 否</p>																			
<p>9. Please provide names, addresses and dates of doctors and facilities which the Insured has been referred and/or admitted to for diagnosis/treatment of this current episode / illness. 請提供受保人就此病症獲得診斷 / 治療之醫生和醫療機構名稱、地址及日期。</p> <table border="1"> <thead> <tr> <th>Name of physician / facility 醫生 / 醫療機構名稱</th> <th>Address 地址</th> <th>Date of consultation / confinement period 求診 / 入住日期</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>				Name of physician / facility 醫生 / 醫療機構名稱	Address 地址	Date of consultation / confinement period 求診 / 入住日期													
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DETAILS OF THE INSURED'S ILLNESS 受保人之病症詳情

1. Please provide the full and exact details of the diagnosis. 請提供與診斷相關之完整及確實的詳情。
2. Please describe the initial episode. 請描述首次病發情況。 i. Date of the episode 病發日期 _____ (DD日/MM月/YY年) ii. Nature of the episode 病發性質 _____ iii. Duration of acute symptoms 急性徵狀持續時間 _____ iv. Date of return to normal activities and/or the insured's present limitations, physical and mental 恢復正常活動之所需時間·及/或受保人現時身體上及精神上之限制 _____
3. Please comment on any neurological sequela which lasted more than 24 hours. 請詳述任何持續超過24小時的神經系統後遺症。
4. Are these sequelae permanent? 這些後遺症是否永久？
5. Has there been an infarction of brain tissue, cerebral haemorrhage or embolization from an extracranial source? 受保人是否曾有腦組織梗塞、腦出血或顱外血管栓塞情況？
6. Please enclose copies of all reports including all reports, radiological procedures, CT scanning, laboratory evidence, other imaging studies, etc. and any relevant medical reports that are available. 請提供所有報告·包括放射程序、電腦斷層掃描、化驗證據、其他影像診斷等·及任何其他相關醫療報告。
7. Please state if the Insured has suffered / been treated for any other illness(es) / complaints other than this Critical Illness. 如受保人曾確診此危疾以外的其他病症或獲得治療·請在此說明。
8. Please provide any further information, which in your opinion will assist us in assessing this claim. 請提供其他有助審核本索償個案的資料。

I hereby certify that I have personally examined and treated the above-named Insured for the above disability and that the facts as given above represent my opinion of his/her condition. 本人在此聲明·本人親自檢查及治療上述受保人之病症·以上陳述乃本人對受保人健康狀況之意見。

Name of doctor and qualification
醫生名稱及醫學資格

Signature and official chop
簽署及蓋印

Address and telephone number
地址及電話

Date
日期