

PART II : ATTENDING PHYSICIAN'S STATEMENT 第二部份：醫生報告

病者姓名： _____ 年齡： _____ 身份證號碼： _____
 Patient's Name : _____ Age : _____ ID Card No. : _____

NOTE 注意： No claim will be admitted unless the report below is duly completed by the medical attendant of the Patient. YF Life Insurance International Ltd will not be responsible for any fee for the completion of this report.
 本報告必須由病者之主診醫生填寫。萬通保險國際有限公司不會負責填寫此報告之費用。

| Questions 問 | Answers 答 | | | | | | | | | | | | | | | | |
|--|--|---------------------------------------|---|---------------------------------------|---|---------------------------------|--------------------------|-------|-------|--------------------------|--------------------------|-------|-------|--------------------------|--------------------------|-------|-------|
| 1. How long have you known the patient? If you know this patient prior to the consultation of the claimed illness / injury, how did you know this patient? 閣下與病者相識多久? 若閣下並非因此疾病 / 受傷而與病者相識, 請詳列認識之經過。 | 1. | | | | | | | | | | | | | | | | |
| 2. Was the patient referred to you by another doctor? If yes, please give us his / her name and address. 病者是否由其他醫生轉介予閣下? 如是, 請提供該醫生的姓名及地址。 | 2. <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 | | | | | | | | | | | | | | | | |
| 3a. When did you first attend that patient for the claimed illness / injury? 閣下於何時首次因是次疾病 / 受傷首次與病者會面? | 3a. | | | | | | | | | | | | | | | | |
| 3b. What were the complaints and symptoms presented? How severe was the condition? How frequent was the attack? 請列明病者之症狀? 嚴重程度? 病發頻率? | 3b. | | | | | | | | | | | | | | | | |
| 3c. How long has the patient been experienced such symptoms prior to first consultation? How did you know this information? 於首次求診前, 病者的症狀持續多久? 閣下如何得悉有關資料? | 3c. | | | | | | | | | | | | | | | | |
| 3d. How long do you think the symptoms has lasted prior to the first consultation to you? Did you inform the patient of your opinion? 閣下認為此症狀於首次求診前可能已持續多久? 有否將閣下之意見知會病者? 如有, 於何時? | 3d. | | | | | | | | | | | | | | | | |
| 4. Had any laboratory test such as cytological studies, x-ray, electrocardiography (ECG), cardiac enzyme levels (CK-MB / Troponin I / Troponin T / AccuTnl), pathology or serological studies been performed? Please give details and provide us with a set of the results if available. 病者曾否接受化驗檢查, 如細胞檢查、X 光檢查、心電圖測試、心臟酵素的水平 (CK-MB / Troponin I / Troponin T / AccuTnl)、病理檢查或血清檢驗? 請詳細列明及提供有關報告予本公司。 | 4. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;"><u>Date Performed</u> 檢查日期</th> <th style="text-align: center;"><u>Details of Procedure</u> 詳細過程</th> <th style="text-align: center;"><u>Results of the test(s)</u> 報告結果</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table> | <u>Date Performed</u> 檢查日期 | <u>Details of Procedure</u> 詳細過程 | <u>Results of the test(s)</u> 報告結果 | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | |
| 5. Please list down the date and details of each visit of the patient to your clinic / hospital in the order of dates. 請詳列病者過往求診的日期及詳情。 | 5. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;"><u>Date</u> 日期</th> <th style="text-align: center;"><u>Symptom</u> 病徵</th> <th style="text-align: center;"><u>Diagnosis</u> 診斷</th> <th style="text-align: center;"><u>Treatment / Physiotherapy and Length of Course</u> 治療 / 物理治療及療程時段</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table> | <u>Date</u> 日期 | <u>Symptom</u> 病徵 | <u>Diagnosis</u> 診斷 | <u>Treatment / Physiotherapy and Length of Course</u> 治療 / 物理治療及療程時段 | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | |
| 6. Please list down all hospitalization record(s) of the patient. 請列出病者所有住院紀錄。 | 6. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;"><u>Admitted on</u> 入院日期</th> <th style="text-align: center;"><u>Discharged on</u> 出院日期</th> <th style="text-align: center;"><u>Diagnosis</u> 診斷</th> <th style="text-align: center;"><u>Treatment</u> 治療</th> <th style="text-align: center;"><u>Name of Hospital</u> 醫院名稱</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table> | <u>Admitted on</u> 入院日期 | <u>Discharged on</u> 出院日期 | <u>Diagnosis</u> 診斷 | <u>Treatment</u> 治療 | <u>Name of Hospital</u> 醫院名稱 | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | |
| 7. Are there any plan for chemotherapy, radiotherapy or surgical operation? Please provide the details. 是否已計劃進行化療 / 電療治療 / 手術? 請提供詳情。 a. Chemotherapy 化療 b. Radiotherapy 電療 c. Surgical operation 手術 | 7. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;"><u>No</u> 否</th> <th style="text-align: center;"><u>Yes</u> 是</th> <th style="text-align: center;"><u>Date</u> 日期</th> <th style="text-align: center;"><u>Details</u> 詳情</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> <td>_____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> <td>_____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> | <u>No</u> 否 | <u>Yes</u> 是 | <u>Date</u> 日期 | <u>Details</u> 詳情 | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
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| <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | | | | | | | | | | | | | | |

Signature of the attending physician / specialist (with chop) :
 主診醫生簽署及蓋章

| | |
|---|---|
| <p>8a. Has the patient previously suffered from same or similar disorders? 病者過往是否患有相同或相似的疾病?</p> <p>8b. If yes, please give the date and details of each disorder. 若有，請提供日期及詳細疾病資料。</p> <p>8c. If not, do you consider that the disability caused by any other disease or disorder? If yes, please provide name of the disease or disorder and how it relates to this illness / disorder. (If available, please provide the date and the details when the patient was aware of such pre-existing illness or disorder). 若沒有，閣下是否認為是次傷殘或疾病是由其他疾病 / 異常情況所導致? 若是，請提供該疾病 / 異常情況之名稱及列明該情況如何與是次疾病有關。(請提供病者已知舊患之日期及詳情)</p> | <p>8a. <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是</p> <p>8b. <u>Date of occurrence</u> <u>Exact Nature /</u> <u>Test / Treatment</u> <u>Duration</u> <u>Doctor Attended</u> 發病日期 發病原因 治療 殘疾持續日期 主診醫生</p> <p>8c.</p> |
| <p>9a. What was your final diagnosis? Please also give the date of diagnosis. 閣下之最後診斷為何? 診斷日期?</p> <p>9b. Was the diagnosis made before the patient first consulted to you (as mentioned in Question 3a)? If yes, please give details. 診斷日期是否早於初次向閣下求診日期 (問題 3a 註明之答案)? 若是，請提供詳情。</p> | <p>9a. Final Diagnosis : 最後診斷 Date of Diagnosis : / / 診斷日期 MM 月 DD 日 CCYY 年</p> <p>9b.</p> |
| <p>10a. Please provide the period of Total Disability of the patient (i.e., prevented the patient from engaging in any occupation, or performing any work for remuneration or profit). 請提供病者之完全傷殘時期 (使病者無法從事任何可獲報酬的職業或工作)。</p> <p>10b. Please provide the period of Partial Disability of the patient (i.e., prevented the patient from engaging in one or more major duties pertaining to his / her own occupation). 請提供病者之部份傷殘時期 (使病者無法從事本身職業內一項或多項主要職責)。</p> <p>10c. Would you expect that the patient remain in the same disability condition as above which continuously requires medical treatment? Please give reason. 閣下是否認為病者將維持上述傷殘情況，並需繼續接受醫療診治? 請列明原因。</p> <p>10d. For how long would the patient remain in the above condition? Please let us know the rehabilitation plan to the patient. 上述之情況仍會持續多久? 請詳述提供予病者康復治療之計劃。</p> | <p>10a. From / / To / / 由 MM 月 DD 日 CCYY 年 至 MM 月 DD 日 CCYY 年</p> <p>10b. From / / To / / 由 MM 月 DD 日 CCYY 年 至 MM 月 DD 日 CCYY 年</p> <p>10c.</p> <p>10d.</p> |
| <p>11a. When did you see the patient recently? 閣下最近於何時約見病者?</p> <p>11b. What was the condition of the patient? 病者的情況如何?</p> | <p>11a.</p> <p>11b.</p> |
| <p>12. Did you have any other information to supplement the above? If yes, please give us in details. 閣下有否其他資料補充? 若有，請詳述。</p> | <p>12.</p> |
| <p>13. Please give the name and address of other doctors who have treated the patient. 請提供有關曾經治療此病者之醫生姓名及地址。</p> | <p>13.</p> |

I hereby certify that I have personally attended the above named Patient and that all the information supplied by me on this form is true and correct to the best of my knowledge and belief.

本人現聲明本人曾提供治療予上述病者，就本人所知所信，上述的資料均為事實之全部，並確實無訛。

Signature of Medical Attendant (with chop) 主診醫生簽名及蓋章

Hospital Specialty / Unit / Department 醫院專科 / 單位 / 部門

Name of Medical Attendant/Qualification(s) 主診醫生姓名 / 專業資格

Date 日期