Disability - Attending Physician Statement (To be completed by the insured's attending doctor of the insured's cost)
傷殘-主診醫生報告（此欄須由受保人之主診醫生填寫）

Full name of Patient _____ HK Identity Card No. _____ Age_____ Sex _____
病人姓名 香港身份證號碼 年齡 性別

Q1. About the medical conditions. Please state 請提供以下有關病況資料

1a. Please state the exact final diagnosis 最後診斷

_____

1b. Investigations, treatment, therapy, surgical procedures done and result for the above mentioned diagnosis:
上述診斷之檢查、治療、手術項目及結果：

_____

1c. Please list all medical consultations, hospital confinement, surgical procedure and course of medical therapy relating to the disability. 請列出病人曾就此病況而求診、住院或接受手術及治療之有關紀錄及詳情。

Date/Period 日期/期間	Type of medical 主要治療項目	Treatment Details 詳情
_____	_____	_____
_____	_____	_____
_____	_____	_____

Q2. About the medical history. Please state 請提供以下有關病歷資料

2a. When did the first consultation take place for the related signs and symptoms? 病人何時開始就有關病徵求診？

_____

2b. What sign(s) and symptom(s) was/were being aware of at the onset of the disability? 病發時有那些主要徵狀？

_____

2c. According to the patient, for how long had such symptom(s) persisted before the first consultation?
根據病人自述，上述病徵持續了多久才首次求醫？

_____

2d. Was the patient referred to you by another doctor for further management？If so, please state the name of referral doctor:
病人是否由另一位醫生轉介台端作進一步治療？如是，請提供轉介醫生之姓名：

_____

Q3. Temporary Total Disability 暫時完全傷殘
(If the disability are expected to be temporary 如上述傷殘預計為暫時性質)

3a. Please state the period of sick leave that you/your hospital granted to the patient? 請提供閣下/求診醫院給予病人之病假?

From 由 _____ YY//MM/DD to 至 _____ YY/MM/DD

3b. According to the occupation of the patient, please indicate the period of disability. 據傷者之職業,請提供其傷殘之時段

b1. Inability to perform one or partial duties不能從事其一或部份之工作

from 由 _____ YY/MM/DD to 至 _____YY/MM/DD

b2. Inability to perform each and every duties不能從事全部之工作

from 由 _____YY/MM/DD to 至 _____YY/MM/DD

3c. In what ways & how did the injury prevent the patient from his/her working/any occupation as indicated above (b1.& b2.) Please give details. 其傷殘是如何及怎樣阻礙病人從事上述之工作/職業 ？ 請詳述

_____

_____

Q4. Permanent Total Disability 永久完全傷殘

(If the disability are expected to be permanent and irrecoverable 如上述傷殘預計為永久及不能康復)

4a. With the current health condition of the patient, please rate the extent of the patient's physical impairment as follows: 就病人現時之健康狀況而言，請評估其工作能力:

☐ Class 1 No limitation of functional capacity; capable of heavy/manual work; no any restrictions.
第一級 能夠從事任何體力勞動工作
☐ Class 2 Capable of medium manual activity
第二級 能夠從事中度體力勞動工作
☐ Class 3 Slightly limitation of functional capacity; capable of light work
第三級 只能從事輕度體力勞動工作
☐ Class 4 Moderate limitation of functional capacity; capable of clerical/administrative activity
第四級 只可從事非體力勞動或文書工作
☐ Class 5 Severe limitation of functional capacity, incapable of minimal activity.
第五級 不能從事任何體力勞動或文書工作

Q5. Please indicate if the medical condition and its subsequent treatment are associated with the following:

如此病與下列情況有關，請註明

☐ Congenital anomalies, infertility or sterilization 先天性不正常，不育或絕育情況
☐ Dental care, general check up 牙科治療，身體檢查
☐ Under the influence of drugs or alcohol 受酒精或藥物影響
☐ Rest cure, rehabilitation, convalescence or extended care 休養，復康或延續護理
☐ Self-inflicted injuries or suicidal attempt while sane or insane 不論在神智清醒與否下之自我損傷或自殺行為
☐ Mental, psychiatric problems 心理，精神病科
☐ Pregnancy conditions or any related complications 懷孕或由此引發之病況
☐ Cosmetic / Plastic surgery 整形外科手術
☐ None of the above 不是上述任何一個

Any further information you want to supplement to us in assessing the claim.其他有助審核本索償個案之資料。

_____

_____

_____ _____

Signature of Physician
醫生簽署

Hospital/Physician Stamp
醫院/醫生蓋印

_____ _____

醫生姓名
Physician Name in Block

簽署日期
Date Signed

駐診地址
Clinic Address of Physician_____