To be completed by Attending Physician's Statement (at the Insured Person's own expenses)
主診醫生之填寫（所需費用由受保人負責）

We would be most grateful if you could attach copies of any specialist or hospital reports, together with any test, or similar evidence to support the validity of your patient's claim. 請附上任何有關專科診治、住院報告、測試檢查或其他證明文件，以協助病人的索償申請。

Patient Name (in full) 病人姓名：

Date of Admission 入院日期：	DD 日	MM 月	YYYY 年	Date of Discharge 出院日期：	DD 日	MM 月	YYYY 年

Name of Hospital 醫院名稱：

Level of hospital ward: 病房級別： ☐ Private 頭等房 ☐ Semi-private 二等房 ☐ Ward 三等房 ☐ Day Care Surgery 日間手術

1. Clinical History 門診病歷：

a. Date on which the patient first consulted you related to this illness/ injury (DD/ MM/ YY)
病人首次就有關疾病／受傷情況之診治日期（日／月／年）

b. Symptom(s)/ complaint(s) of the patient relating to this hospitalization/ treatment/ investigation
病人就有關是次住院／接受治療／檢查之徵狀／疾病

c. How long had the patient been experiencing these symptoms before the first consultation?
病人之病徵於首次求診前出現了多久？

Since _____(DD/MM/YY) OR for _____day(s)_____ month(s) _____year(s)

從 日/月/年 或 已存在 日 月 年

2. Hospitalisation Details 住院詳情：

a. Final Diagnosis
最後診斷

Date of Operation (DD/ MM/ YYYY)
手術日期（日／月／年）

b. Operation procedure(s) performed
手術詳情

c. If the patient has consulted other physician during this hospitalisation, please provide the following:
如病人於是次住院期間曾向其他醫生求診，請提供以下資料：

Name of physician consulted
醫生姓名

Reason
原因

What treatment had the physician performed?
該醫生曾提供甚麼治療？

d. Please give a brief discharge summary (including onset and duration of signs and symptoms/ disease, etiology, types and results of major examinations, treatments, complications and follow up plan)
請提供出院摘要（包括病發及疾病徵狀、病因、類型及主要檢查、治療、併發症之結果及跟進計劃）

e. Please provide reason(s) for hospitalisation if this type of cases can be managed on day care/out-patient basis.
假若這類個案可於日間護理／門診護理，請提供入住醫院原因。

3. Professional Comment 專業意見：

a. To the best of your knowledge, Other than this episode, has the patient ever been treated for the same / related conditions?
據閣下所知，除了此次病症，病人曾否患有同類／相關病況而接受治療？ ☐ Yes 是 ☐ No 否
If yes, please provide the dates of consultation, details of conditions and diagnosis.
如有，請說明何時及當時情況。

b. Was the condition due to or associated with the following? (Please tick the appropriate boxes)
病人的病況是否與下列情況有關？（請於適當之空格加上「✓」）

☐ None of above 以上都不是	☐ Pregnancy 懷孕	☐ Congenital condition 先天性疾病
☐ Accidental bodily injury 意外受傷	☐ Infertility or sterilization 不育或絕育	☐ Developmental condition 發展障礙
☐ Self-inflicted injury 自戕	☐ Contraception 節育	☐ Hereditary condition 遺傳性疾病
☐ Abuse of drugs or alcohol 濫用藥物或酗酒	☐ Treatment for cosmetic purpose 美容手術	☐ General check-up 一般身體檢查
☐ Mental or nervous disorder 精神／神經病	☐ Vaccination 防疫注射	☐ Refractive error 視力問題

☐ Venereal disease, sexually transmitted disease or AIDS/ HIV related illness 性病、性傳染疾病或愛滋病／與 HIV 有關之疾病

4. Others 其他：

a. If the patient was referred by another doctor, please provide the referring doctor's name and address.
如病人為其他醫生轉介，請提供該轉介醫生之姓名及地址。

b. Are you the patient's usual physician? 你是否病人慣常之醫生？ ☐ Yes 是 ☐ No 否

I hereby certify that all information given above is accurate and true to the best of my knowledge.
本人證明上述的資料根據本人所知皆為正確無訛。

Signature and chop of attending physician/ surgeon 主診醫生簽署及蓋章 Address and telephone no. 地址及聯絡電話

Name of attending physician/surgeon & qualifications 主診醫生姓名及認可資格 Date 日期： MM 日 DD 月 YYYY 年