



**PART II – ATTENDING PHYSICIAN’S STATEMENT (Fill by attending physician, at the claimant’s own expenses)**  
**第二部份 – 主診醫生證明書 (由主診醫生填寫，所需費用由索償人承擔)**

Patient Name (in full) 病人姓名	Date of Admission (DD/MM/YY) 入院日期(日/月/年)	Date of Discharge (DD/MM/YY) 出院日期(日/月/年)
<b>1. Clinical history of this patient : 門診病歷</b>		
a) Date on which the patient first consulted you related to this medical condition(s) / injury 病人首次就上述病況或有關疾病或受傷之求診日期		
Symptoms and complaints for this hospitalization/treatment 病人是次主要因何癥狀或不適入院		
b) Underlying cause(s) of this hospitalization 引致是次住院之主要原因		
c) According to the medical history given by the patient, how long had he/she been experiencing these symptoms before the 1 <sup>st</sup> consultation 病人初次求診時，該病癥已出現多久？		
How long, in your opinion, has the patient been suffering from this illness? 您認為病人患有該疾病多久？		
<b>2. Hospitalization History of this patient : 住院病歷</b>		
a) Final Diagnosis 診斷結果	Date of Operation 手術日期	
b) Operational procedure(s) performed 手術名稱		
If you have consulted other doctor during this hospitalization, please provide the following 於住院期間，如曾將病者轉介往其他醫生，請提供下列有關資料:		
Consulted Doctor's Name: 醫生姓名	Reason : 轉介原因	
What treatment had the doctor performed 治療名稱		
c) Please give brief discharge summary (including onset and duration of signs and symptoms/disease, etiology, types and results of major examinations, treatment, complications and follow up plan) 出院摘要：(請列出有關疾病及病徵的病發日期、病因、檢驗性質及結果、有關治療、併發症及跟進計劃。)		
d) Has the patient taken any home leave during this hospitalization ? if "yes", please state the date, time and reason 於住院期間，病者有否請假外出？如“有”，請列明日期、時間及原因		
e) Please provide reason(s) for hospitalization if this type of cases can be managed on day care / out-patient basis. 如是次住院可在日間病房進行，請提供住院原因		
<b>3. Professional comment 專業意見:</b>		
a) In your opinion, was the hospitalized illness a recurrent episode or a chronic illness or related to previous complaint/diagnosis. If "yes", please provide date of the first episode and details. 就閣下意見，是次病況是否為復發性病症或慢性病症？如“是”，請提供首次復發日期。		
b) Has the patient even had the same symptoms before/has the patient been treated or hospitalized for the same symptoms before? 病者以前曾否患有同類病況？ If "yes", please state, to the best of your knowledge, on a separate sheet when and describe details (including a brief summary describing the onset date, duration of signs and symptoms, disease, etiology types and results of major examinations, treatments, complications and follow-up plan.) 如“是”，請說明日期及詳情 (請另頁書寫並簽署作實)		
c) Was the condition due to or associated with the following ( Please circle the right answers) 上述情況是否因下列問題所致？(請圈出有關項目) Accidental bodily injury, abuse of drugs or alcohol, AIDS/HIV related illness, venereal disease or sexually transmitted disease, pregnancy, infertility or sterilization, refractive error, cosmetic or plastic surgery, mental or nervous disorder, congenital condition, hereditary condition, developmental condition, self-inflicted injury, general check up or none of the above. 身體意外受傷/濫用藥物或酒精/後天免疫力缺乏症(愛滋病)/與人類免疫力缺乏病毒(HIV)、性病或因性接觸感染之疾病/懷孕、不育或絕育/視力不正常/美容或整容手術/精神病/先天性症狀或疾病/遺傳性症狀或疾病/發育期狀況/自我傷害/一般身體檢查或防疫注射/以上全不適用		
d) If the condition is due to pregnancy, please advise the date of the LMP : 如上述情況由懷孕引致，請說明最後經期日期		
<b>4. Others : 其他</b>		
If you are referred by another doctor, please provide the referring doctor's name and address : 如閣下乃由其他醫生轉介，請提供該醫生姓名及地址：		
I hereby certify that all information given above is accurate and true to the best of my knowledge 本人謹此聲明，以上所填報之資料，均屬真實無訛。		
Signature of attending doctor/Surgeon with Practice/Hospital Stamp 主診/外科醫生簽署/醫院蓋章		Address and Telephone No. 地址及電話
Name of attending doctor/Surgeon 主診/外科醫生姓名		Date (DD/MM/YY) 日期(日/月/年)