# CONFIDENTIAL MEDICAL CERTIFICATE－醫生報告

**PART II - To be completed by doctor at Insured's / Claimant's expense 第二部份（受保人或申請人自費由主診醫生填寫)**

| Policy Number 保單號碼 | |
|---|---|
| Name of Insured 受保人姓名 | ID Card / Passport No. 身分證 / 護照號碼 |

## CRITICAL ILLNESS－BACTERIAL MENINGITIS / LESS SEVERE BACTERIAL MENINGITIS / MENINGEAL TUBERCULOSIS
## 危疾－細菌性腦（脊）膜炎 / 次級嚴重細菌性腦（脊）膜炎 / 腦膜結核病

**GENERAL INFORMATION 一般資料**

1. Are you the Insured's usual medical physician?
   閣下是否受保人慣常求診之醫生？ ☐ Yes 是 ☐ No 否
   If "yes", when did the Insured first consult you? 如"是"，請問受保人首次向閣下求診之日期？
   ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年

2. When were you first consulted for this illness?
   受保人首次就有關疾病向閣下求診之日期。
   ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年
   What were the symptoms? 受保人之病徵。
   _____
   How long had the symptoms been present? 該病徵約存在了多久?
   _____

3. Has the Insured previously suffered from this illness or any related conditions?
   受保人是否有同類之病史？ ☐ Yes 是 ☐ No 否
   If "yes", please give dates of consultations and the resulting diagnosis. 如"有"，請提供求診日期及診斷詳細結果。
   _____

4. On which date was the diagnosis made? 有關疾病之診斷是何時首次確認？
   ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年
   On which date was the Insured first made aware of it? 受保人何時首次知悉有關疾病之診斷？
   ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年

5. Is there anything in the Insured's family history which would have increased the risk of this illness?
   受保人之家族病史是否增加受保人患上此病之機會？ ☐ Yes 是 ☐ No 否

6. Is the Insured a smoker? 受保人是否吸煙人仕？ ☐ Yes 是 ☐ No 否
   If "Yes", what is his / her smoking habit? 若為吸煙人仕，他 / 她的吸煙習慣為何？
   Daily smoking amount 每日吸煙數量：_____ for how many years? 吸食年數：_____

7. Other physicians or medical facilities the patient has consulted for this condition.
   受保人曾經就診之其他醫生或醫療機構資料。

| Name of physician / facility 醫生 / 機構名稱 | Address 地址 | Date of consultation / confinement period 求診日期 / 住院時段 |
|---|---|---|
| | | |
| | | |
| | | |

Details of "Yes" answers (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities).
如答"是"，請提供診斷結果、日期、病徵持續時期及主診醫生姓名、醫療機構名稱及地址等資料。

## DETAILS OF THE INSURED'S ILLNESS 受保人病況之詳情

8. Please provide full and exact details of the diagnosis. 請提供受保人之所有及確定的診斷詳情。

9. Etiology? 病因為何？

10. Was the diagnosis confirmed by a neurologist?
此疾病是否經腦神經專科醫生確診？ ☐ Yes 是 ☐ No 否

Please give the Name and Address of the neurologist confirming the diagnosis if it is not the undersigned.
若非由填寫此表格之醫生確診，請提供確診之腦神經專科醫生的姓名及地址。

_____

11. The site of the meningitis involved. 腦(脊)膜炎的正確位置。
☐ Membranes of the brain 腦膜 ☐ Spinal Cord 脊髓

Others 其他：_____

12. i. Was there a lumbar puncture confirming the presence of bacterial infection in the cerebrospinal fluid?
是否以腰椎穿刺證實腦脊髓液受細菌感染？ ☐ Yes 是 ☐ No 否

ii. When and where was lumbar puncture performed?
腰椎穿刺於何時及何處進行?

☐☐ ☐☐ ☐☐☐☐
MM月 DD日 YYYY年

Name and Address of the Institution
進行腰椎穿刺之機構名稱及地址：

_____

iii. Please state the result of lumbar puncture and the type of bacteria found. 請列明腰椎穿刺之結果及何種細菌存在。

_____

14. Please state all the investigations done to prove acute bacterial infection of the meninges.
請列出所有可証明為急性腦（脊）膜受細菌感染的檢查項目。

| Dates<br>日期 | Procedures<br>檢查項目 / 名稱 | Results<br>結果 |
|---|---|---|
| | | |
| | | |
| | | |

Note : Please enclose copies of all reports, including biopsy reports, cytology reports, X-rays, CT scans, MRI, USG and other imaging studies, laboratory tests, surgical report, etc. and any relevant hospital reports that are available.
備註：請提供所有報告包括活體檢視記錄、細胞分析報告、X光檢查、電腦掃描、磁力共振、超聲波、其他影像、化驗及手術報告等，或任何有關的醫院報告。

15. Was hospitalization required due to bacterial meningitis?
有否因為腦（脊）膜發炎而需要接受住院治療？ ☐ Yes 是 ☐ No 否

If "yes", please state the period(s) of hospital confinement(s).
如"有"，請列出住院時段。

From 由 ☐☐ ☐☐ ☐☐☐☐ To 至 ☐☐ ☐☐ ☐☐☐☐
MM月 DD日 YYYY年 MM月 DD日 YYYY年

Name of Hospital
醫院名稱：_____

Name of Attending Doctor
主診醫生名稱：_____

16. Was there any surgery performed?
受保人有否接受手術治療？ ☐ Yes 是 ☐ No 否

If "Yes", please state the details of the surgical procedure(s)?
如"有"，請列出曾接受之手術詳情。

_____

17. Was there any significant and serious neurological deficit resulted?
是否出現因腦(脊)膜炎導致任何嚴重的神經虧損？ ☐ Yes 是 ☐ No 否

If "Yes", please give details of the deficit and state how long it has been documented.
如"是"，請列明神經虧損之狀況及該狀況約存在了多久。

_____

Was the neurological deficit expected to be temporary or permanent?
該神經虧損估計是屬暫時性還是永久性？ ☐ Temporary 暫時性 ☐ Permanent 永久性

Was the neurological deficit resulted in motor weakness or cranial nerve dysfunction?
該神經虧損是否引致運動機能缺損或顱神經功能障礙？ ☐ Yes 是 ☐ No 否

If "Yes", please state how long it has been documented.
如"是"，請列明該情況持續了多久。

_____

18. What is the prognosis?
病情進展？

19. Please state if the Insured has suffered / been treated for any other major illness(es) in the past.
請列明受保人曾患上或接受治療的其他主要疾病。

20. Is there 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之資料。

I / We hereby declare that the information given on this form is true and complete to the best of my / our knowledge and belief.
本人 / 我們現聲明此申請書上所填資料皆為本人 / 我們所知及所信之事實及其全部。

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該聲明的符合相關守則及法規之最新版本可於以上網址下載及可供索取。

Name of doctor and qualification 醫生姓名及醫學資格

Signature and official chop 簽署及蓋印

Address and telephone number 地址及聯絡電話

Date 日期

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