CHUBB

Agent's/Intermediary's name 保險代理 / 中介人姓名 _____

Agent's/Intermediary's contact phone no. 保險代理 / 中介人聯絡電話 _____

Agent's/Intermediary's code 保險代理 / 中介人代號 _____

Agency 組別 ___ – ___

Claim Form - Hospitalization/Surgery

住院 / 手術賠償申請書

Claim Type 賠償類別

- ☐ Hospital & Surgery Benefit
- ☐ Hospital Cash Benefit
- ☐ Select Top Up Medical Benefit
- ☐ VCARE Cancer Protector Benefit
- ☐ VHIS Benefit
- ☐ AMS
- ☐ Clinical surgery/Daycase surgery
- ☐ Other benefits, please specify: _____
- ☐ Request return of Certified True Copy of Medical Receipt(s)

☐ New claim 首次索償	☐ Pending claim 待決索償	☐ Further claim 再度索償	☐ Review/appeal 重批/覆核
	Please provide claim no. for reference 請提供賠償編號以作參考		

Part I (To Be Completed by Policyowner/Insured) 第一部份（由保單持有人 / 受保人填寫）

A. Insured's Particulars 受保人資料

1. Policy no. 保單編號			
2. Name of Insured 受保人姓名		3. Sex/Age 性別/年齡	
4. Identity document no. 身份證明文件號碼		5. Date of birth 出生日期	/ / DD日 MM月 YYYY年
6. Tel. no. 電話號碼		7. Email address 電郵地址	
8. Residential Address 居住地址			
9. Name of Employer 僱主（公司）名稱			
10. Address of Employer 僱主（公司）地址			
11. Present Occupation 現職			

12. Has the lnsured resided for 183 days or above within 12 months preceding the time of medical treatment/service in the USA? (only applicable to AMS claim)
受保人是否於美國接受治療/醫療服務前之十二個月內已於該地居住達一百八十三日或以上？（只適用於 AMS 索償） ☐ Yes 是 ☐ No 否

13. Will the Insured apply for compensation from other insurance company(ies)/organization(s) for the same event?
受保人是否會就是次事件向其他保險公司/機構申請賠償？ ☐ Yes 是 ☐ No 否

If "Yes", please provide below information. 若「是」，請提供下列所需資料。

a) Insurance Company/Organization 保險公司/機構	b) Policy number 保單編號	c) Benefit to claim 保障類別	d) Benefit amount 保障金額

B. If Hospitalization/Surgery was caused by ILLNESS, details as below 如因疾病住院或進行手術，詳情如下

1. Sign and symptoms 徵狀	
2. For this episode, since when have these symptoms first appeared? 就是次病況而言，何時出現首次徵狀？	_____ / _____ / _____ Day日 Month月 Year年

3. Other than this episode, have you had any similar/related past history? ☐ No 沒有 ☐ Yes, please provide below information
除了此次病況，閣下以往有否類似或相關的病歷？ 有，請提供下列所需資料

a) Consultation Date (DD/MM/YYYY) 就診日期（日/月/年）	b) Name of Physician/Hospital 醫生姓名/醫院名稱	c) Diagnosis 診斷結果	d) Progress of Recovery with dates 康復進度及日期

4. Please provide details of usual Physician(s)/Hospital(s). Please provide the information in reverse chronological order.
請提供慣常求診之醫生或醫院資料。請由最近期起按時序寫醫生/醫院資料。

a) Since (Month/Year) 自從（月/年）	b) Name of Physician/Hospital 醫生姓名/醫院名稱	c) Contact Phone No. 聯絡電話號碼

C. If Hospitalization/Day Surgery was caused by ACCIDENT, details as below 如因意外住院或進行手術，詳情如下

1. Date of Accident & Time 意外發生之日期及時間	_____ / _____ / _____ _____ hh: _____ mm (am/pm) Day日 Month月 Year年 時 分（早上/下午）	2. Location of Accident 意外發生之地點	
3. Details of Accident (Please describe activities engaged and how the body part(s) was injured) 意外詳情 （請形容當時進行之活動及如何受傷）			
4. Describe part(s) of body injured and nature of injury 請說明受傷部位及性質			
5. Did you report to the police? 閣下有否報警？	☐ No 沒有 ☐ Yes, please provide information on the right 有，請提供右方所需的資料	a) Police Station 警署地點	
		b) Case Ref. Number 檔案編號	

Remarks: Please attach a photocopy of the Police Report/Traffic Accident Report/Police Statement/Alcohol Test Report. (if applicable)
註：請附上警察報告/交通意外報告/口供紙/酒精測試報告影印本。（如適用）

D. Consultation/Hospitalization/Day Surgery Details 診治/住院/日間手術之詳情

1. Information of the Physician first consulted for this illness 首次就診之醫生資料

a) Consultation Date (DD/MM/YYYY) 就診日期（日/月/年）	b) Name of Physician/Medical Provider 醫生姓名/醫療機構名稱	c) Contact Phone No. 聯絡電話號碼

2. Information of the Physician who referred to hospital 建議入院之醫生資料

a) Referral Date (DD/MM/YYYY) 轉介日期（日/月/年）	b) Name of Referral Physician 轉介醫生姓名	c) Contact Phone No. 聯絡電話號碼

3. Details of confinement/consultation 住院/就診詳情

a) Hospitalization Period 住院日期	b) Name of Hospital 醫院名稱	
From 由 ____ Day日 / ____ Month月 / ____ Year年 To 至 ____ Day日 / ____ Month月 / ____ Year年	c) Name of Physician 醫生姓名	

E. Settlement Option 賠償支付方式

☐ **Direct credit to existing premium collection autopay account (bank account which is held by the policyowner)**
轉賬至現時用於繳交保費之戶口 (銀行戶口持有人必須為保單持有人)

☐ **HKD Bank Draft (drawn in Mainland China)**
港幣本票 (於中國內地兌現)

☐ **Direct Credit to Bank Account 直接存入銀行戶口**

IMPORTANT MESSAGE: ONLY applicable to the policy **WITHOUT** autopay bank account for premium payment. Otherwise, the payment will be credited to autopay bank account which is held by the policyowner directly.
重要信息：只適用於**不是**以自動轉賬形式收取保費的保單，否則，款項將直接存入自動轉賬的銀行戶口（銀行戶口持有人必須為保單持有人）。

Name of Bank Account Holder (**MUST BE** the policyowner)
銀行戶口持有人姓名 (**必須**為保單持有人)

Bank Name
銀行名稱

Bank No. 銀行編號	Branch No. 分行編號	Bank Account No. 銀行賬户號碼

*Please provide copy of passbook/bank statement/ATM card with name of account.
*請提供存摺/銀行戶口結單/提款卡副本(附有銀行戶口持有人的姓名)以作核實。

☐ **TT Payment 滙款**

Remittance charges will be borne by the policyowner
滙款的相關費用將由保單持有人支付

- Name of Bank Account Holder 銀行戶口持有人姓名
- Bank Account No. 銀行戶口號碼
- SWIFT Code SWIFT 代號
- Bank Name 銀行名稱
- Bank Address 銀行地址
- IBAN No. 國際銀行賬戶號碼
- Intermediary Bank Name 中介銀行名稱
- Intermediary Bank Account No. 中介銀行戶口號碼

Remarks 備註：

1) Bank charges may be incurred by client for clearing the bank draft and TT. Policyowner is recommended to check with the bank before applying this instruction.
銀行或會向閣下徵收兌現本票或電匯的相關手續費。建議保單持有人於遞交指示前先向銀行查詢。
2) For payment by direct credit to bank account, bank account holder must be the policyowner and the maximum claim payment limit is HK$200,000.
若選擇直接存入銀行戶口，銀行戶口持有人必須為保單持有人及賠償金額上限為港幣200,000元。
3) For the claim payment amount exceeding HKD200,000, HKD cheque will be issued and sent to agent/intermediary (if applicable) directly.
如賠償金額多於港幣200,000元，將發出港幣支票並直接送予保險代理 / 中介人（如適用）。
4) If unspecified or without clear instruction, claim payment will be settled by direct credit to existing premium collection autopay bank account (only applicable for the maximum claim payment limit is HKD200,000 and the aforesaid bank account holder is policyowner). Otherwise, claim HKD cheque will be issued and sent to agent/intermediary (if applicable) directly.
如沒有註明或清晰指示，賠償金額將會以直接轉賬至現時用於繳交保費之戶口（僅適用於賠償金額上限為港幣200,000元及銀行戶口持有人必須為保單持有人）（如有），否則將發出港幣支票並直接送予保險代理 / 中介人（如適用）。

For Agent's/Intermediary's Use Only 保險代理 / 中介人適用

Attachment 附件	☐ HKID card copy of Insured 受保人之香港身份證副本	☐ HKID card copy of Policyowner 保單持有人之香港身份證副本

I/We have verified the original HKID card/passport/residential address proof of the policyowner/insured and confirmed the identity details in the HKID card/passport to be matched with the identity of the policyowner/insured in this claim form. I/We will provide the required information and copies of the relevant documents to Chubb Life Insurance Hong Kong Limited without delay.

本人 / 吾等已核對保單持有人 / 受保人之香港身份證 / 護照 / 居住地址證明之正本，並確認香港身份證 / 護照之身份資料與此賠償申請書上保單持有人 / 受保人之資料一致。本人 / 吾等將會儘快遞交有關文件之副本予安達人壽保險香港有限公司。

Agent's/Intermediary's name
保險代理 / 中介人姓名：_____

Agent's/Intermediary's code
保險代理 / 中介人代號：_____

Agency
組別：_____

Agent's/Intermediary's signature 保險代理 / 中介人簽署：_____ Sign date 簽署日期：_____
(DD日 MM月 YYYY年)

Claims Document Checklist 索償文件清單

Basic required documents 基本所需文件	• Completed and signed Claim Form Part I and Part II 已填妥及簽署之理賠申請書第一及第二部份 • Original Medical Receipt(s) and Statement(s) of Charges 醫療正本收據及收費單（費用明細表） • Copy of Discharge Summary/Discharge Slip 出院總結 / 出院紙副本 • Copy of Laboratory/X-Ray/CT scan/MRI/Pathological Report(s) 化驗/X-光/電腦掃描/磁力共振/病理檢驗報告副本 • Copy of Identity Document of Life Assured & Policyowner 受保人及保單持有人之身份證明文件副本 • Copy of Admission Note, Discharge Summary, Discharge Certificate, Daily Medical Record & Temperature Sheet of hospital in Mainland China 中國內地醫院之病案首頁、入院紀錄、出院證明、每日醫囑單及體溫表副本 • Copy of Settlement Advice from another insurance provider, if any 其他保險機構之理賠通知書副本（如有）
Additional document 附加文件	• Copy of Sick Leave Certificate with clear diagnosis 列有診斷證明之病假證明書副本 • Copy of Referral Letter by Registered Physician/Hospital 註冊醫生/醫院轉介信副本 • Certified true copy of travel document for overseas hospitalization 旅遊文件（海外住院適用） • Compensation breakdown from other insurer party 其他保險公司/機構之賠償細算表 • Certified true copy of medical receipts and statement of charges issued by other insurance companies 由其他保險公司發出之醫療費用收據及收費單之核證副本 • Detail breakdown of receipt items 收費明細表 • Police report/traffic accident report/statement (if apply) 警察報告/交通意外報告/口供紙（如適用）

Note: In order to speed up your claim application, please attach the above documents together with this application form. Should any extra information or document be required for your claim processing, we will notify you or your agent or intermediary. We reserve the right to request for the submission of the optional documents if necessary.

註：為使能儘速辦理 閣下的索償申請，請將此表格連同以上文件遞交。如需要額外資料或文件，我們將另函通知 閣下或 閣下的保險代理或中介人。本公司保留要求客戶提交附加文件之權利。

F. Personal Information Collection Statement 個人資料收集聲明

I/WE HEREBY ACKNOWLEDGE, DECLARE AND AGREE THAT, by signing this form, any personal information collected or held by Chubb Life Insurance Hong Kong Limited (the "Company") is provided and may be used, processed, stored, disclosed, transferred by the Company to the transferees indicated in and in accordance with the Personal Information Collection Statement set out in my/our Application For Life Insurance, which may include without limitation, any branch, subsidiary, holding company, associated company or affiliates of the Company (the "Group Companies"), its authorized agents, reinsurers, claims investigators, loss adjudicators, medical advisors, recovery agents, insurance industry associations and federations, credit reference agencies, government or judicial or regulatory bodies or any person to whom the Company is under legal and/or regulatory obligation to make disclosure, and the Company's appointed third party agents, contractors and advisors, in each case whether within or outside of Hong Kong and Mainland China. Moreover, the Company is hereby authorized to obtain access to and/or to verify any of my/our personal information with the information collected by the insurance industry associations, the federations, the government and regulatory bodies and medical personnel or organizations. I/We am/are obliged to supply the information required from me/us under this form which is a condition precedent for me/us to apply for claims assessment, processing and other services. Failure to supply the required information may result in the Company being unable to process this form. For more details of the Company's policies on personal information and privacy protection, please read the Company's Privacy Notice available at https://www.chubb.com/hk-en/footer/chubb-life-privacy-policy.html. Any questions regarding personal information, access to or correction of personal information should be made in writing and forwarded to The Data Protection Officer of Chubb Life Insurance Hong Kong Limited at 35/F, Chubb Tower, Windsor House, 311 Gloucester Road, Causeway Bay, Hong Kong.

就簽署此表格，本人/吾等確認、聲明及同意安達人壽保險香港有限公司（「貴公司」）可以使用、處理、儲存、披露、轉移任何貴公司所收集或持有任何本人/吾等的個人資料至在本人/吾等的人壽保險申請書中的個人資料收集聲明所訂明的資料轉移接收方，包括但不限於，貴公司的任何分行、附屬公司、控股公司、聯營公司或聯繫公司(「集團公司」)、其獲授權的代理人、再保險公司、理賠調查公司、理賠調查員、醫療顧問、索償代理、保險行業協會及聯會、信貸資料機構、政府或司法或監管機構或對貴公司具有法律及/或監管責任而須予以披露的任何人士，及貴公司指定的第三方代理、承包商及顧問，不論在香港及中國大陸境內或境外。此外，貴公司獲授權向保險行業協會及聯會、政府及監管機構、及醫務人員或機構取閱及/或核實任何該等機構向本人/吾等收集之個人資料。本人/吾等有責任提供此表格上所需資料，以作為索償評估,處理及其他服務之先決條件。如未能提供所需的資料，可能會導致貴公司無法處理本表格。有關安達人壽保險香港有限公司個人資料及私隱保障政策的詳情，請參閱安達人壽保險香港有限公司的私隱政策，網址為https://www.chubb.com/hk-zh/footer/chubb-life-privacy-policy.html。如欲查詢有關個人資料事宜，查閱或更正個人資料必須以書面形式向安達人壽保險香港有限公司的資料保護主任提出，並送交至香港銅鑼灣告士打道三一一號皇室大廈安達人壽大樓三十五樓 。

G. Authorization 授權

I hereby irrevocably authorize or authorize on behalf of the Insured (if different) (i) any employer, doctor, hospital, clinic, insurance company, government office or any organizations or persons who have any records, knowledge or information (whether medical or otherwise) of me or the Insured (if different) to disclose, release or transfer to Chubb Life Insurance Hong Kong Limited "the **Company**"or its representative such information pertinent to this claim; (ii) the Company or any of its appointed medical/para-medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate my or the Insured (if different) health status in relation to this claim. This authorization shall bind my and the Insured's successors and assignees and remain valid notwithstanding my or the Insured's death or incapacity in so far as legally possible. A photocopy of this Authorization shall be valid as the original.

本人或受保人授權（如有不同）(i) 任何僱主、醫生、醫院、診所、保險公司、政府部門，或其他機構及人士，如具有本人 / 受保人（如不同）的任何紀錄、知識或資料，可將該等資料向貴公司或貴公司代表透露、發放或移交，用以作為該份索償申請的參考；(ii)　貴公司或貴公司委任的醫療 / 輔助醫療檢查員或檢驗所，就有關索償的申請，進行醫療評估或測驗，以檢定本人 / 受保人（如有不同）的健康狀況。該授權書對本人 / 受保人的繼承人及承讓人均有約束力，即使在本人 / 受保人（如有不同）死亡或喪失行為能力後仍然有效。該授權書的影印本具有與正本同等的效力。

I/We agree to the Company may deduct any outstanding levy from the policy payment amount.
本人/吾等同意貴公司或會從保單的給付金額中扣除任何逾期的保費徵費。

_____ / _____ / _____ Day 日 Month 月 Year 年	Signature of Policyowner (if other than Insured) 保單持有人簽名（如並非受保人）	Name of Policyowner 保單持有人姓名
		Identity Document Number of Policyowner 保單持有人身份證明文件號碼
_____ / _____ / _____ Day 日 Month 月 Year 年	Signature of Insured 受保人簽名	Name of Insured 受保人姓名
		Identity Document Number of Insured 受保人身份證明文件號碼

Please DO NOT sign on BLANK form 請勿在空白表格上簽署

* In compliance with the Anti-Money Laundering and Counter-Terrorist Financing (Financial Institutions) Ordinance and the Guideline on Anti-Money Laundering and Counter-Terrorist Financing which is issued by the Insurance Authority as amended from time to time, **Chubb Life Insurance Hong Kong Limited** is required to collect the identity information for the above items with asterisk (*) and verify the identity of the Policyowner. Your agent/intermediary, therefore, is needed to verify the original identification documents and collect the copies of the relevant and other documents as deemed necessary of the Policyowner.

* 根據打擊洗錢及恐怖分子資金籌集（金融機構）條例及保險業監理處所發出及不時修訂之「打擊洗錢及恐怖分子資金籌集指引」，**安達人壽保險香港有限公司**必須收取以上註有星號 (*) 項目之保單持有人身份資料並核實保單持有人之身份。閣下之保險代理 / 中介人必須核實保單持有人之正本身份證明文件，並收取有關及其他所須文件之副本。

Part II – Attending Physician's Statement (To Be Completed by Attending Physician at the Applicant's Own Expense)

第二部份－主診醫生報告（由主診醫生填寫，填寫報告費用須申請人自付） **Policy No.** | | | | | | | | | | |

A. Patient Information 病人資料

1. Name of Patient 病人姓名		2. Identity Document Number 身份證明文件號碼	
3. Age 年齡		4. Sex 性別	
5. Are you the patient's usual physician? 閣下是否病人慣常求診之醫生？	☐ No 否 ☐ Yes, medical records since: 是，醫療紀錄開始日期： _____ / _____ / _____ Day 日 Month 月 Year 年		

B. Consultation Details 診治資料

1. Date on which the patient **FIRST** consulted you for this illness or injury 有關是次病症或受傷，病人**首次**向 閣下求診的日期	_____ / _____ / _____ Day 日 Month 月 Year 年		
2. Signs and symptoms complained of at the **FIRST** consultation **首次**求診時出現的徵狀			
3. Cause of Consultation 求診原因	a) ☐ Accident 意外 Date of accident 意外日期 _____ / _____ / _____ Day 日 Month 月 Year 年 Time of Accident 意外時間 ☐ AM 上午 / ☐ PM 下午 _____ : _____ Time 時間	b) ☐ Illness 病症 How long had the patient been experiencing these sign and symptoms BEFORE the first consultation? 首次求診前其徵狀已存在多久？ _____ Day(s) 日 _____ Month(s) 月 _____ Year(s) 年 Or since 或自 _____ / _____ / _____ Day 日 Month 月 Year 年	
4. For this episode, had the patient previously seen other physician(s) for these symptoms? 就此次病症而言，病人之前有否就有關之病況向其他醫生求診？	☐ No 沒有 ☐ Yes, please provide information on the right 有，請提供右方所需資料	a) Name of Physician 醫生姓名	
		b) Address of Physician 醫生地址	
		c) Date 日期	_____ / _____ / _____ Day 日 Month 月 Year 年

C. Hospitalization Or Treatment Details 住院或治療詳情

1. Name of Hospital/Medical Provider 醫院/醫療機構名稱

2. ☐ Clinic 診所 ☐ Hospital OPD 醫院門診部 ☐ In-patient 住院 ☐ Day Case 日症

3. Bed Class 住院級別 ☐ Private 私家房 ☐ Semi-private 半私家房 ☐ Ward 大房 ☐ Other, please specify 其他，請註明：_____

4. Date of admission 入院日期	_____ / _____ / _____ Day 日 Month 月 Year 年	5. Date of discharge 出院日期	_____ / _____ / _____ Day 日 Month 月 Year 年

6. Had the patient confined in Intensive Care Unit 病人有否入住深切治療部？	☐ No 否 ☐ Yes 有 If "Yes", please provide details 如「有」，請提供詳情 a) From 由 _____ / _____ / _____ Day日 Month月 Year年 To 至 _____ / _____ / _____ Day日 Month月 Year年
	b) Reason 原因

7. Any home leave taken by the patient during the said hospitalization period? 病人在上述住院期間有否請假離院？	☐ No 否 ☐ Yes 有 If "Yes", please provide details 如「有」，請提供詳情 a) From 由 _____ / _____ / _____ (Day日 / Month月 / Year年) _____ : _____ (Time 時間) ☐ AM 上午 / ☐ PM 下午 To 至 _____ / _____ / _____ (Day日 / Month月 / Year年) _____ : _____ (Time 時間) ☐ AM 上午 / ☐ PM 下午
	b) Reason 原因

8. a) Final Diagnosis 最後診斷		b) Underlying cause(s) 病因	c) First diagnosis date 首次診斷日期
i)			_____ / _____ / _____ Day日 Month月 Year年
ii)			_____ / _____ / _____ Day日 Month月 Year年
iii)			_____ / _____ / _____ Day日 Month月 Year年

9. Was surgery performed? 有否進行手術？	☐ No 否 ☐ Yes 有 If "Yes", please provide below information 如「有」，請提供下列所需資料

a) Surgery Name 手術名稱		b) Surgery Date 手術日期	_____ / _____ / _____ Day日 Month月 Year年
c) Surgeon Name 外科醫生姓名		d) Mode of Anesthesia 麻醉方式	☐ G.A 全身麻醉 ☐ L.A. 局部麻醉

10.a) Please state the recommended diagnostic tests and the reason for the tests during this hospitalization. 請註明是次住院所建議的診斷性檢查之名稱及原因。	
b) Summary of medical treatment given and tests performed with results. 總結有關治療及檢驗結果。	

Remarks: Please attach copies of histopathology/endoscopic/diagnostic/laboratory test report/operation summary, etc.
註：請連同病理檢驗/內窺鏡/診斷性化驗/檢驗報告/手術撮要等副本一併交回。

11. Can this type of treatment/ test be managed on daycare or out-patient basis? 此次病症之治療/檢查是否可於日間中心或門診內進行?	☐ No 否 ☐ Yes 是 If "Yes", please provide below information 如「是」，請提供下列所需資料 a) Please provide reason(s) for this hospitalization. 請提供是次住院的原因。 _____ b) If hospitalization is arranged for scans, diagnostic testing or a procedure that is normally carried out in a day case, please explain reason of hospital stay is necessary. 如是次住院之目的為檢驗，進行診斷或一般日症手術，請說明住院之原因。 _____

12. Did you refer the patient to another physician or hospital? 閣下有否轉介病人往其他醫生或醫院？	☐ No 否 ☐ Yes 有 If "Yes", please provide below information 如「有」，請提供下列所需資料

a) Name of the physician/hospital 醫生姓名/醫院名稱	b) Speciality 所屬專科

c) Details for the referral reason
詳述轉介原因

13. The prognosis of the condition 預計痊癒後的情況	☐ Good 良好 ☐ Fair 一般 ☐ Poor 甚差
14. Possibility of relapse? 有否復發的可能?	☐ No 否 ☐ Yes 有 If "Yes", please explain in details 如「有」，請詳細解釋

15. To the best of your knowledge, was the patient's injury/illness directly or indirectly due to or aggravated by the following
根據 閣下所知，病人是否因以下之原因，直接或間接引致或加劇有關之受傷/病症

☐ No 否 ☐ Yes, please tick where it is appropriate and provide details
是，請在適當的位置劃上剔號及提供詳情

- ☐ Congenital condition/anomalies 先天性不正常情況
- ☐ Alcohol/narcotics/drug abuse 酗酒/濫用毒品/濫用藥物
- ☐ Self-inflicted injuries 自我傷害
- ☐ Geriatric; psychogeriatric or psychiatric condition 老年病、老年精神病或精神病情況
- ☐ Sexually transmitted diseases 性接觸傳染的疾病
- ☐ Pregnancy, miscarriage, child birth, infertility or any related complications 懷孕、流產、生產、不育或由此引發之病況
- ☐ Treatment of obesity 肥胖治療
- ☐ Experimental and/or unconventional medical technology/procedure/therapy performed on the Insured; or novel drugs/medicines/ stem cell therapy 醫療實驗治療或未經相關機構批准之新型藥物或幹細胞治療
- ☐ Convalescence, custodial or rest care 療養、復康護理
- ☐ Cosmetic or plastic surgery 美容或整形手術
- ☐ Corrective aids or treatment of refractive errors 視力矯正
- ☐ Hazardous sport/activity 參與危險性運動/活動
- ☐ AIDS/AIDS related compiex disease 後天免疫力缺乏症/與後天免疫力缺乏症相關的綜合症
- ☐ Body check/vaccination & immunization injections 身體檢查/防疫注射
- ☐ Developmental or behavioral problem 發育問題或行為問題
- ☐ Dental care/treatment 牙科護理/治療

please provide details 請提供詳情

16. If Hospitalization is arranged for scans, diagnostic testing or a procedure that is normally carried out in a day case, please explain reason of Hospital stay is necessary 如是次住院之目的為檢驗，進行診斷掃描或一般日症手術，請說明留院之原因

D. Medical History Details 病歷詳情

1. Other than this episode, have you had any similar/related past history? ☐ No 沒有 ☐ Yes, please provide below information
除了此次病況，閣下以往有否類似或相關的病歷？ 有，請提供下列所需資料

a) Consultation Date (DD/MM/YYYY) 就診日期（日/月/年）	b) Name of Physician/Hospital 醫生姓名/醫院名稱	c) Diagnosis 診斷結果	d) Progress of Recovery with dates 康復進度及日期

2. a) Did the patient have the following **PAST** medical history/habit? 病人**過往**有否以下之病史/習慣？

☐ No 否 ☐ Yes, please tick where it is appropriate and provide details
是，請在適當的位置劃上剔號及提供詳情

☐ Asthma 哮喘
☐ Hepatitis B 乙型肝炎
☐ Previous operation 曾接受手術
☐ Smoking habit 吸煙習慣
☐ Obesity 肥胖症
☐ Cardiac problem 心臟病
☐ Hypertension 高血壓
☐ Hyperlipidaemia 高脂血症
☐ Diabetes mellitus 糖尿病
☐ Unfavorable family history 家族病史
☐ Chronic illness 長期病況
☐ Other, please specify details
其他，請說明詳情 _____

3. Relevant details of **PAST** medical history/habit
過往病史之有關詳情

a) Diagnosis/Disease/Disorder 病況	
b) Name & address of the physician/hospital by whom was the above **PAST** medical history **FIRST** detected **首次**診斷出上述**過往**病史之醫生姓名/醫院名稱及地址	
c) **FIRST** diagnosis date and treatment details of the above **PAST** medical history 上述**過往**病史之**首次**診斷日期及治療詳情	
d) Current prognosis of the above **PAST** medical history 上述**過往**病史癒後的情況	☐ Fully Recovered 完全康復 ☐ On treatment, please provide the ongoing and upcoming treatment details 治療中，請提供現正進行及將來的治療詳情 _____ _____

E. Physician Details 醫生資料

Name of Attending Physician 主診醫生姓名		Qualification 資歷	
Hospital Name (if applicable) 醫院名稱（如適用）		Telephone No. 電話號碼	
Address 地址			
Are you related to the patient in any way other than the professional capacity? 除專業身份外，與病人是否有其他關係？	☐ No 否 ☐ Yes, please specify the relationship with patient 是，請註明與病人之關係 _____		
Signature & Hospital/ Physician's Chop 醫院/醫生簽署及蓋印		Date 日期	

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