



## FirstCare Plus / AXA GI WiseGuard Medical Insurance Claim Form

### 摯關懷超卓 / AXA 安盛保險守慧醫療保障索償表

 <p><b>1) Claim Submission 遞交索償申請</b>          Please complete this claim form and send to AXA <b>Within 90 days</b> after the date on which the insured person (patient) is discharged from the Hospital, or the date on which the relevant medical service is performed and completed.          受保人(病人)請於出院後或(當沒有住院時)進行及完成相關醫療服務後<b>90日內</b>填妥並遞交有關索償申請予AXA安盛</p> <p><b>How to submit my claim? 如何遞交索償申請</b></p> <ul style="list-style-type: none"> <li>▪ In Person: HSBC Branches, OR            親身遞交：經滙豐銀行分行·或</li> <li>▪ By Post: The Claims Department            AXA General Insurance Hong Kong Limited            P.O. Box No. 90854 Tsim Sha Tsui Post Office,            Kowloon, Hong Kong            郵寄至：香港九龍尖沙咀郵政局信箱 90854 號, 索償部收</li> </ul>	 <p><b>2) Claim Result 索償結果</b></p> <ul style="list-style-type: none"> <li>▪ Claims assessment will be completed <b>within 10 working days</b> after all required documents are received            理賠批核將於收到所須文件後<b>10個工作日內</b>完成</li> <li>▪ Actual assessment time maybe prolonged if additional information is required            實際批核時間會因應須要補充資料而延長</li> <li>▪ Upon claims approval, claim payment will be reimbursed to the account you specified during application or by cheque if you did not specify a claims settlement account            當索償批核後·我們會將索償款項轉賬至您於申請時指定之銀行戶口·如您並未指定銀行戶口·索償款項將以支票形式郵寄給您</li> </ul>
<p><b>Remarks 備注</b></p> <ul style="list-style-type: none"> <li>▪ AXA General Insurance Hong Kong Limited may request for additional medical report(s) or supporting documents to assess the claims. Any expenses incurred will be borne by the Policyholder. 安盛保險有限公司可能就索償要求額外醫療報告/資料。所產生之費用須由保單持有人所承擔。</li> <li>▪ For inquiry, please contact AXA at (852) 2867 8678.            如有查詢·請致電AXA安盛 (852) 2867 8678。</li> <li>▪ <b>If the claim submission is for Pre-Confinement/ Day Case Procedure outpatient care, Post-Confinement/ Day Case Procedure outpatient care or Post-Confinement/ Day Case Procedure outpatient ancillary services, please complete all sections of Part I (except Hospitalisation &amp; Surgery).</b> 如遞交入院/日間手術前的門診護理、出院/日間手術後的門診護理或出院/日間手術後門診輔助服務之索償申請·請填妥甲部(除住院及手術欄外)。</li> <li>▪ <b>If the claim submission is for hospitalisation/day case procedure/advanced diagnostic imaging test &amp; cancer treatment, please complete all sections of Part I and Part II of this claim form (except Details of outpatient care in Part I).</b> 如屬住院,日間手術/先進影像診斷檢查/癌症/腫瘤相關疾病索償申請·請填妥索償表甲部及乙部之所有部分(除甲部 - 門診護理詳情外)</li> </ul>	

<b>PART I – TO BE COMPLETED BY INSURED PERSON (PATIENT) 甲部 - 由受保人 (病人) 填寫</b>			
<b>GENERAL INFORMATION 一般資料</b>			
Name of policyholder 保單持有人姓名	<input type="checkbox"/> Mr. 先生 <input type="checkbox"/> Mrs. 太太 <input type="checkbox"/> Miss 小姐 <input type="checkbox"/> Ms. 女士	Surname 姓	Given Name 名
Policy number 保單號碼			
<b>INSURED PERSON'S (PATIENT'S) INFORMATION 受保人(病人)資料</b>			
Note: Please fill in (b) to (d) only if insured person (patient) is same as policyholder. 注意：如受保人(病人)與保單持有人為同一人·只需填妥(b)至(d)。			
(a) Name of insured person (patient) 受保人(病人)姓名	<input type="checkbox"/> Mr. 先生 <input type="checkbox"/> Mrs. 太太 <input type="checkbox"/> Miss 小姐 <input type="checkbox"/> Ms. 女士		
(b) ID type and number 身份證明文件類別及號碼	<input type="checkbox"/> HKID 香港身份證 <input type="checkbox"/> Passport No 護照	Number 號碼：_____	
If insured person (patient) is under 18 years old, please provide HKID / passport Number of policyholder. 如受保人(病人)未滿 18 歲·請提供保單持有人之香港身份證 / 護照號碼			
(c) Mobile number 手機號碼	(d) Email address 電郵地址		
(Use for follow up of this claim 用於跟進是次索償)		(Use for follow up of this claim 用於跟進是次索償)	
<b>DETAILS OF OUTPATIENT CARE 門診護理詳情</b>			
Date of outpatient 門診日期	_____dd 日 _____mm 月 _____yyyy 年		
Period of hospitalisation or date of surgery 住院期間或手術日期	_____dd 日 _____mm 月 _____yyyy 年 至 _____dd 日 _____mm 月 _____yyyy 年		

**Settlement of remaining balance of medical expenses under other AXA policy(ies)**

索償之餘額於AXA安盛生效之保單上提出索償

If you would like to claim for the remaining balance of the medical expenses under your other inforce AXA policy(ies), please provide the policy information of the relevant policy(ies).

如欲將此次索償之餘額於另一AXA安盛生效之保單上提出索償，請提供以下有關保單資料。

Life Policy No. 人壽保險號碼

Non-Life Policy No. 非人壽保險號碼

Group Medical Policy No. 團體醫療保險號碼

**HOSPITALISATION & SURGERY 住院及手術**Hospitalisation / surgery was due to  
住院/手術原因 Illness (go to A) 疾病 (請填甲)

OR 或

 Accident (go to B) 意外 (請填乙)**A. Complete if hospitalisation / surgery was due to illness 甲. 因疾病住院/手術**Describe the symptoms and how long they have appeared  
請詳述病徵及持續多久

\_\_\_\_\_

\_\_\_\_\_

Have you had any prior treatment for this or related condition  
您是否曾經接受任何此類或相關疾病的治療 Yes 是  No 否

If yes, please provide details below. 如是，請提供以下資料

Physician's/  
surgeon's name  
醫生/外科醫生姓名Date  
日期

\_\_\_\_\_dd 日 \_\_\_\_\_mm 月 \_\_\_\_\_yyyy 年

Physician's/  
surgeon's address  
醫生地址

\_\_\_\_\_

\_\_\_\_\_

**B. Complete if hospitalisation / surgery was due to accident 乙. 因意外住院/手術**Information on the accident  
意外資料

Date 日期: \_\_\_\_\_dd 日 \_\_\_\_\_mm 月 \_\_\_\_\_yyyy 年

Time 時間: \_\_\_\_\_

Place 地點: \_\_\_\_\_

Brief description of accident  
意外經過

\_\_\_\_\_

\_\_\_\_\_

**CLAIMS WITH OTHER INSURANCE COMPANY 向其他保險公司索償**Are you making any other insurance  
company claim?  
您是否向其他保險公司申請索償? Yes 是  No 否

If yes, please provide details below. 如是，請提供以下資料

Name of insurance company  
保險公司名稱Policy Number  
保單號碼Request for document return  
退還文件 Please "✓" this box for obtaining Certified True Copy of original invoice(s) and receipt(s) after claim processing.  
如欲索取醫生的發票和收據正式認證副本，請在空格內填上「✓」號。Note 注意: 1) Certified True Copy will not be issued if the claims are fully reimbursed

Note 注意:

1) Certified True Copy will not be issued if the claims are fully reimbursed  
如索償已獲全數賠償，正式認證副本將不獲發出。2) The originals will not be returned and will only be retained for 3 months from the claim processed date  
正本文件將不獲退還，並將只從索賠處理完成日期起計保留 3 個月。**Claims Documents Required 所需文件**

Please ✓ the required documents you have submitted. Our company may request for additional information.

請✓您所提交的文件。本公司有可能就個別情況要求進一步文件證明，以處理索償申請。

Basic documents for all  
claims (must be completed  
and submitted)  
所有索償類別的基本文件 (必須  
完成及遞交)

- Part I completed and signed by Insured Person (Patient)/ Policyholder 由受保人(病人)/保單持有人填妥此表格及簽名
- Part II completed by the attending physician/surgeon with signature and chop (to be obtained by Insured Person (Patient) / Policyholder) / 外科醫生填妥此表格乙部，簽名及蓋章(由索償人/受保人(保單持有人)索取主診醫生/外科醫生填妥此表格乙部，簽名及蓋章(由受保人(病人)/保單持有人索取)主診醫生/外科醫生填妥此表格乙部，簽名及蓋章(由受保人(病人)/保單持有人索取)
- Original receipt(s) of the medical expenses 醫療費用收據正本
- Settlement advice from other insurer, if any 請提供其他保險公司之賠償結算通知，如適用

Additional document (if  
applicable)  
附加文件 (如適用)

- If the patient is confined in government hospital (managed by Hospital Authority, ward level), discharge summary would replace the completion of claim form part II 如入住香港醫院管理局轄下公立醫院之普通病房，出院摘要可替代索償表之乙部
- Copies of histopathology, endoscopic, diagnostic, laboratory tests report, operating theatre summary 請連同病理學，內窺鏡，診斷性化驗/檢驗報告，手術室摘要副本交回
- Meal breakdown record 膳食記錄
- Hospitalisation surgical package charges breakdown 住院/手術套餐費細目，如適用

## DECLARATION AND AUTHORISATION 聲明及授權書

- I/WE HEREBY DECLARE AND AGREE that (1) all statements and answers to all questions whether or not written by my/our own hand are to the best of my/our knowledge and belief complete and true; (2) AXA General Insurance Hong Kong Limited (the "Company") is not bound by and is not required to rely on any statement which I/We may have made to any person if not written or printed here.
- I/WE HEREBY AUTHORISE (1) any employer, medical practitioner, paramedical examiners, hospital, clinic, insurance company, bank, financial institution, police, government institution, or other organisation, institution or person, that has any records or knowledge of me/us to disclose such information to AXA General Insurance Hong Kong Limited ("the Company"); (2) the Company or any of its appointed medical examiners, paramedical examiners or laboratories to perform the necessary medical assessments and tests to evaluate in relation to this claim. This authorisation shall bind the successors of and remains valid notwithstanding death or incapacity. A photocopy of this authorisation shall be as valid as the original.
- In relation to the personal data collected in this form and provided during the course of the claim process, I/WE ACKNOWLEDGE AND CONFIRM that:
  - (unless specifically indicated otherwise in this form) the personal data requested in this form (or otherwise provided during the course of the claim process) ("Personal Data") is necessary for AXA General Insurance Hong Kong Limited (the "Company") to process the insurance claim and any such data not provided may mean the claim may not be able to be processed;
  - the Personal Data may be used by the Company for purposes which include
    - providing to me/us the products / services of the Company, other companies of the AXA Group ("your affiliates") or your business partners, and administering, maintaining, managing and operating such products / services;
    - processing and evaluating any applications or requests made by me/us for products / services offered by the Company and your affiliates;
    - providing subsequent services to me/us, including but not limited to administering the policies issued;
    - any purposes in connection with any claims made by or against or otherwise involving me/us in respect of any products / services provided by the Company and / or your affiliates, including investigation of claims;
    - detecting and preventing fraud (whether or not relating to the products/services provided by the Company and/or our affiliates);
    - evaluating my/our financial needs; evaluating my/our financial needs;
    - designing products / services for customers;
    - conducting market research for statistical or other purposes;
    - matching any data held which relates to me/us from time to time for any of the purposes listed herein;
    - making disclosure as required by any applicable law, rules, regulations, codes of practice or guidelines or to assist in law enforcement purposes, investigations by police or other government or regulatory authorities in Hong Kong or elsewhere;
    - conducting identity and / or credit checks and / or debt collection;
    - complying with the laws of any applicable jurisdiction;
    - carrying out other services in connection with the operation of the Company's business; and
    - other purposes directly relating to any of the above.
  - the Personal Data will be kept confidential but, subject to the provisions of any applicable law, may be provided to:
    - any of your affiliates, any person associated with the Company, any reinsurance company, claims investigation company, my/our broker, industry association or federation, fund management company or financial institution in Hong Kong or elsewhere and in this regard my/our consent to the transfer of my/our data outside of Hong Kong;
    - any person (including private investigators) in connection with any claims made by or against or otherwise involving me/us in respect of any products / services provided by the Company and / or your affiliates;
    - any agent, contractor or third party who provides administrative, technology or other services to the Company and / or your affiliates in Hong Kong or elsewhere and who has a duty of confidentiality to the same;
    - credit reference agencies or, in the event of default, debt collection agencies;
    - any actual or proposed assignee, transferee, participant or sub-participant of our rights or business;
    - any government department or other appropriate governmental or regulatory authority in Hong Kong or elsewhere; and
    - the following persons who may collect and use the data only as reasonably necessary to carry out any of the purposes described in paragraphs nos. (2) of the Purposes specified above: insurance adjusters, agents and brokers, employers, health care professionals, hospitals, accountants, financial advisors, solicitors, organisations that consolidate claims and underwriting information for the insurance industry, fraud prevention organisations, other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), the police and databases or registers (and their operators) used by the insurance industry to analyse and check data provided against existing data.
  - I/WE may gain access to, or request correction of my/our personal data (in both cases, may be subject to a reasonable fee) at any time by writing to: Data Privacy Officer of AXA General Insurance Hong Kong Limited at 5/F AXA Southside, 38 Wong Chuk Hang Road, Wong Chuk Hang, Hong Kong.
- I/WE ACKNOWLEDGE AND CONFIRM that the Personal Data may be provided to
  - The Hongkong and Shanghai Banking Corporation Limited ("HSBC") for any of the purposes listed above in 3.(2) and for the following additional bank related purposes: ensuring ongoing credit worthiness of customers, creating and maintaining credit and risk related models, providing the personal data to credit reference agencies for the purposes of conducting credit checks and other directly related purposes, determining the amount of indebtedness owed to or by customers and collection of amounts outstanding from customers and those providing security for customers' obligations.  
\* This is applicable only if you are applying for a product and/or service of, or making a request to, the Company through HSBC as the Company's distribution agent. The Personal Data will not be provided to HSBC for any of the purposes listed above in 3.(2) if you do not apply for the product and/or service of, or make a request to, the Company through HSBC as the Company's distribution agent.

- 本人/我們謹此聲明及同意(1)上述一切陳述及問題的所有答案·不論是否本人/我們親手所寫·就本人/我們所知所信·均為事實全部並確實無訛;(2)本人/我們對任何人所作出的任何聲明·如沒有在此申請書上填寫或印出·安盛保險有限公司(「貴公司」)不須受其約束。
- 本人/我們茲授權(1)任何僱主·註冊西醫·醫療人員·醫院·診所·保險公司·銀行·財務機構·警察·政府機構·或其他組織·機構或人士·凡知道或持有任何本人/我們之紀錄者·均可將該等資料提供給安盛保險有限公司;(2)安盛保險有限公司或任何其指定之醫生或化驗所·可就此賠償申請替本人/我們進行所需之醫療評估及測試·作為審核本人/我們之索償·此授權對本人/我們之繼承人具有約束力;即使本人/我們身故或無行為能力時·此授權仍具效力·本授權書的影印本與正本均有同等效力。
- 就有關從此索償表及於處理索償時所收集的個人資料·本人/我們知悉及確認:
  - 除非於本表格上另有訂明·本表格所要求提供的個人資料(或於處理索償時所要求提供的個人資料)(「個人資料」)是供安盛保險有限公司(「貴公司」)處理保險索償申請的所需資料·若未能提供任何所需資料索償申請則可能不被處理;
  - 貴公司所收集之個人資料之用途包括:
    - 提供貴公司·安盛集團的其他公司(「安盛關聯方」)或貴公司的商業合作夥伴之產品/服務·以及提供·維持·管理和操作該等產品/服務;
    - 處理和評估本人/我們就貴公司及安盛關聯方所提供之產品/服務提出的任何申請或要求;
    - 向本人/我們提供後續服務·包括但不限於執行/管理已發出的保單;
    - 與就貴公司和/或安盛關聯方提供的任何產品/服務而由本人/我們或針對本人/我們提出的或者其他涉及本人/我們的任何索賠相關的任何目的·包括索賠調查;
    - 偵測和防止欺詐行為(無論是否與就由本公司及/或安盛關聯方提供的產品/服務有關);
    - 評估本人/我們的財務需求;評估本人/我們的財務需求;
    - 為客戶設計產品/服務;
    - 為統計或其他目的進行市場研究;
    - 不時就此處所列的任何目的核對所持有的與本人/我們有關的任何資料;
    - 作出任何適用法律·規則·規例·實務守則或指引所要求的披露或協助在香港或香港以外其他地方的警方或其他政府或監管機構執法及進行調查;
    - 進行身份和/或信用核查和/或債務追收;
    - 遵守任何適用的司法管轄區的法律;
    - 開展與貴公司業務經營有關的其他服務;及
    - 與上述任何目的直接有關的其他目的。

- (3) 個人資料將予以保密，但在遵守任何適用法律條文的前提下，可提供給：
- 位於香港或香港以外其他地方的任何安盛關聯方、貴公司的任何相關聯人士、任何再保險公司、索賠調查公司、本人/我們之保險經紀、行業協會或聯會、基金管理公司或金融機構，以及就此方面而言，本人/我們同意將本人/我們的資料轉移至香港境外；
  - 與就貴公司和 / 或安盛關聯方提供的任何產品 / 服務而由本人/我們或針對本人/我們提出的或者其他涉及本人/我們的任何索賠相關的任何人士(包括私家偵探)；
  - 在香港或香港以外其他地方向貴公司和 / 或安盛關聯方提供行政、技術或其他服務並對個人資料負有保密義務的任何代理、承包商或第三方；
  - 信貸資料機構或(在出現拖欠還款的情況下)追討欠款公司；
  - 貴公司權利或業務的任何實際或建議的承讓人、受讓方、參與者或次參與者；
  - 在香港或香港以外其他地方的任何政府部門或其他適當的政府或監管機關；及
  - 在有合理需要履行任何上述有關目的段落(2)之情況下，以下人士：保險理算人、代理和經紀、僱主、醫護專業人士、醫院、會計師、財務顧問、律師、整合保險業申訴和承保資料的組織、防欺詐組織、其他保險公司(無論是直接地，或是通過防欺詐組織或本段中指名的其他人士)、警察、和保險業就現有資料而對所提供的資料作出分析和檢查的數據庫或登記冊(及其運營者)。

(4) 本人/我們可隨時致函致安盛保險有限公司之個人資料保護主任(地址：香港黃竹坑黃竹坑道 38 號安盛匯 5 樓)查閱、或要求修改本人/我們的個人資料(貴公司可能就查閱及修改要求收取合理費用)。

4. 本人/我們知悉及確認個人資料可提供給

\* 就任何有關關於 3.(2)之目的和下列與銀行有關的額外目的提供給香港上海滙豐銀行有限公司(“滙豐”)：確保客戶信貸信譽度持續良好，建立和維持信貸及風險的相關模型，為進行信用核查以及其他直接相關的目的而向信貸資料服務機構提供個人資料，確定尚欠客戶的債務或客戶所欠債務的金額以及向客戶和為客戶的欠款

提供擔保之人追收未償款項。

\* 此僅適用於您透過滙豐(作為本公司的分銷代理人)申請本公司的產品和/或服務或者透過滙豐(作為本公司的分銷代理人)向本公司提出要求的情況。如果您並未透過滙豐(作為本公司的分銷代理人)申請本公司的產品和/或服務或者透過滙豐(作為本公司的分銷代理人)向本公司提出要求，您的個人資料將不會因上文 3.(2)

所述的任何有關目而提供給滙豐。

<input type="checkbox"/> Signature of insured person (patient) 受保人(病人)簽署 OR 或 <input type="checkbox"/> Signature of policyholder (if insured person is under 18 years old or a full time student aged 23 or below)		Date 日期	_____dd 日 _____mm 月 _____yyyy 年
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**Important Notes 重要事項：**

The above policy is underwritten by AXA General Insurance Hong Kong Limited (“AXA”), which is authorised and regulated by the Insurance Authority of the Hong Kong SAR. AXA will be responsible for providing your insurance coverage and handling claims under your policy. The Hongkong and Shanghai Banking Corporation Limited is registered in accordance with the Insurance Ordinance (Cap. 41 of the Laws of Hong Kong) as an insurance agent of AXA for distribution of general insurance products in the Hong Kong SAR. 以上保單由安盛保險有限公司(「AXA安盛」)承保，AXA安盛已獲香港保險業監管局授權並受其監管。AXA安盛將負責按保單條款為您提供保險保障以及處理索償申請。香港上海滙豐銀行有限公司乃根據保險業條例(香港法例第 41 章)註冊為AXA安盛於香港特別行政區分銷一般保險產品之授權保險代理商。

Issued by AXA General Insurance Hong Kong Limited 由安盛保險有限公司刊發

**PART II - TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON AT THE INSURED PERSON'S (PATIENT'S)/POLICYHOLDER'S OWN EXPENSE**

乙部 - 由主診醫生 / 外科醫生填寫，所需費用由受保人(病人)/保單持有人自行承擔

**1. GENERAL INFORMATION 一般資料**

Name of insured person (patient) 受保人(病人)姓名	
Date of birth (dd/mm/yyyy) 出生日期(日/月/年)	

**2. CLINICAL HISTORY 臨床病歷**

First consultation date (dd/mm/yyyy) 首次看診日期(日/月/年)	Symptom(s) / chief complaint(s) presented 出現病徵/主訴 Onset Date (dd/mm/yyyy) 病徵出現日期(日/月/年)	
How long had the patient been experiencing these symptoms before the first consultation 病人在首次求診前已經歷了該病徵有多久	Diagnosis (ICD 10 Codes) 最後的診斷	
Is it a chronic / recurrent illness 是否慢性 / 復發疾病	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	

**3. ABOUT HOSPITALISATION / DAY CASE PROCEDURE / ADVANCED DIAGNOSTIC IMAGING TEST****有關住院/日間手術/先進影像診斷檢查**

Name of hospital / day case procedure centre / medical clinic 醫院/日間手術護理中心/醫療診所	<input type="checkbox"/> Inpatient 住院 <input type="checkbox"/> Hospital OPD 醫院門診 <input type="checkbox"/> Day Centre 日間中心 <input type="checkbox"/> Clinic 診所		
Bed class 住院級別	<input type="checkbox"/> Private 私家房 <input type="checkbox"/> Semi-private 半私家房 <input type="checkbox"/> Ward 大房 <input type="checkbox"/> Hospital day ward 醫院日症 <input type="checkbox"/> Day case procedure centre 日間手術護理中心 / Medical clinic 醫療診所		
Date of admission/treatment (dd/mm/yyyy) 入院/治療日期(日/月/年)		Date of discharge (dd/mm/yyyy) 出院日期(日/月/年)	
Final diagnosis at the time of discharge 出院時最後的診斷		ICD 10 Code	
Name of surgery / treatment 手術名稱或治療		CPT Codes	
Has the patient been consulted by other Physician/ Surgeon(s) during this hospitalisation 如病人於住院期間曾向其他醫/外科醫生求診	Name of Physician/ Surgeon 醫生/外科醫生姓名 Reason 原因 Treatment Performed 治療詳情		
Please provide details of the hospitalisation, including treatment, investigations, tests conducted, on-going treatment and recovery plan. 請提供是次住院詳情，包括相關治療、檢查、測試結果、持續治療及康復計劃。			
Did the patient take any home leave during the hospital confinement? If yes, please specify the reason and the period of home leave 病人是否於住院期間離院？如有，請註明該離院時段和原因	<input type="checkbox"/> Yes 是 Reason 原因 _____ <input type="checkbox"/> No 否		
Please provide details of the period of hospitalisation including reasons for number of days as in-patient. 請提供是次持續留院日數及其原因。	_____ _____		
Is it possible that the treatments / investigations of the patient be managed on an out-patient basis? 病人的治療 / 檢查是否可在門診進行？	<input type="checkbox"/> Yes 是	Please provide reason(s) for this hospitalisation 請提供是次必須留院受治療之原因 _____	
	<input type="checkbox"/> No 否	Please provide reason(s) 請提供原因 _____	

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4. PROFESSIONAL COMMENT 專業意見	
In your opinion, was the hospitalisation a result of recurrent episode/chronic illness or related to a previous condition? 您認為是次住院是因為複發性 / 長期疾病或之前的疾病 / 意外? 如“是”, 請提供日期和說明細節	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 If yes, please provide dates and details. 請提供日期和說明細節 Date 日期: _____ dd 日 _____ mm 月 _____ yyyy 年 Details 細節: _____
Was the condition due to or associated with the following? 上述情況是否與以下問題有關?	<input type="checkbox"/> Accidental bodily injury 意外身體受傷 <input type="checkbox"/> Pregnancy 懷孕 <input type="checkbox"/> Congenital condition 先天性疾病/異常 <input type="checkbox"/> Self-inflicted injury 自我傷害 <input type="checkbox"/> Infertility or sterilization 不育或絕育 <input type="checkbox"/> Developmental condition 發育問題 <input type="checkbox"/> Abuse of drugs or alcohol 濫用藥物或酒精 <input type="checkbox"/> Contraception 避孕 <input type="checkbox"/> Hereditary condition 遺傳性問題 <input type="checkbox"/> Mental disorder 精神紊亂 <input type="checkbox"/> Treatment for cosmetic purpose 美容性質的治療 <input type="checkbox"/> General check-up 一般身體檢查 <input type="checkbox"/> Refractive error 屈光不正 <input type="checkbox"/> Vaccination 疫苗接種 <input type="checkbox"/> Venereal disease, sexually transmitted disease or AIDS/HIV related illness 性病 · 性傳播疾病或愛滋病/愛滋病毒有關的疾病
5. ABOUT THE CANCER TREATMENT 癌症 / 腫瘤相關疾病	
Type of treatment administered 治療種類	<input type="checkbox"/> Surgical 外科治療 <input type="checkbox"/> Hormonal Therapy 荷爾蒙治療    Date of treatment 日期 (dd日/mm月/yyyy年) <input type="checkbox"/> Chemotherapy 化療 <input type="checkbox"/> Target therapy 標靶治療 <input type="checkbox"/> Others 其他 _____ <input type="checkbox"/> Radiotherapy 電療 <input type="checkbox"/> Immunotherapy 免疫療法
Please provide details of the treatment including drug name, dosage, frequency and duration of treatment, all other types of treatment and any complications 請提供治療細節如藥物名稱 · 藥物劑量 · 治療頻率 · 持續治療的時間及其他治療類別和其併發症	

6. ABOUT HEALTH HISTORY 有關診治記錄				
Has the patient previously suffered from related conditions of this illness? If yes, please provide the dates of physician's/ surgeon's consultation/ hospital admission, details of conditions and diagnosis 病人曾否出現與此疾病相關的徵狀? 如有, 請提供醫生/外科醫生就診日期 · 入院日期 · 有關徵狀及診斷				<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
Date of physician's/ surgeon's consultation or hospital admission (dd/mm/yyyy) 醫生/外科醫生就診或住院日期 (日/月/年)	Name of physician/ surgeon or hospital 醫生/外科醫生姓名或醫院名稱	Complaints and symptoms 病徵	Diagnosis 診斷	Treatments given (please state name of surgical procedure if performed or to be performed 所提供的治療 (請列明已接受或將會進行的手術名稱))

7. OTHERS 其它	
Are you the patient's usual physician/ surgeon? 您是否該病人的慣常醫生/外科醫生?	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
Referring physician's/ surgeon's name and address, if applicable 轉介醫生/外科醫生的姓名和地址 · 如適用	
Name of physician/surgeon 醫生/外科醫生姓名	
Telephone 電話號碼	

**DECLARATION AND AUTHORISATION 聲明及授權**

I HEREBY DECLARE AND AGREE that all statements and answers to all questions are to the best of my knowledge and belief complete and true.  
本人謹此聲明及同意上述一切陳述及問題的所有答案，就本人所知所信，均為事實全部並確實無訛。

Signature and chop of attending physician / surgeon

Date: dd/mm/yyyy

主診醫生/ 外科醫生簽名及蓋章

日期(日/月/年)

Name of attending physician / surgeon 主診醫生 / 外科醫生姓名	Qualification 資歷
Telephone 電話號碼	
Address 地址	