Attending Physician Report 主診醫生報告

Part B – To be completed by attending physician 乙部 – 由主診醫生填寫

1. PARTICULARS OF THE PATIENT 病人資料

   Name of Patient 病人姓名 _____ I.D.Card No. 身份證號碼 _____ Age 年齡 _____

2. Date of accident/onset of sickness 意外發生 / 病發日期

   _____

3. a) Describe and locate accurately cause, character and extent of injury of sickness 請敘述受傷或疾病之原因、性質及程度

   _____

   b) Describe the present condition 請敘述現時狀況

   i) Are the symptoms progressive, stationary or improving? 症狀是否惡化、穩定或好轉？

   _____

   ii) Does the disability render the patient totally disabled or partially disabled? 殘疾是否會導致病人完全傷殘或部份傷殘？

   ☐ No 否 ☐ Yes 是 Please state cause of disability 請註明傷殘原因 _____

   _____

4. When did symptoms first appear? 病症何時首次出現？

   _____

5. Date of first and latest consultation 首次及最近診治日期

   First Date 首次日期 _____ Latest Date 最近日期 _____

6. Describe type of treatment, surgical procedure or operation performed 請敘述接受何種治療、手術步驟或外科手術

   _____

7. Give details of any history of physical impairments which may have contributed directly or indirectly to the accident or sickness or which may likely to retard his recovery 請詳述有關病人身體殘缺病歷而會直接或間接阻慢受傷或痴病痊癒程度

   _____

   _____

8. Is condition due to pregnancy? 上述情況是否因懷孕引致？

   _____

9. a) In your opinion, could the patient resume any work for which he is fitted by nature, training and experience? 據閣下意見，病人是否可以利用其訓練及經驗重新從事任何適當工作？

   ☐ No 否 ☐ Yes 是 Please give date to resume work 請提供重新工作日期 _____

   b) If the patient is continuously totally disabled, how long will such total disability continue? 如病人是繼續完全傷殘，此傷殘會維持多久？

   _____

10. Details of Hospitalization 醫院資料

    a) Name of Hospital where treatment was received 入院醫院名稱

    _____

    b) Was the patient admitted as an inpatient or was treatment received as an outpatient? 病人是否需住院或只需在門診接受治療？

    ☐ Inpatient 住院 Period of Hospitalization 住院時期 From 由 _____ To 至 _____ ☐ Outpatient 門診

I hereby certify that having personally examined the above named patient, the facts as set forth are true and correct 本人茲證明以上有關病人之資料乃真實及正確

Signature of attending Physician with Official Chop
主診醫生簽署及蓋章

Name of attending Physician: _____
主診醫生姓名

Qualifications: _____
資歷

Address: _____
地址

_____

Telephone: _____
聯絡電話

_____
Date 日期: