

C. 由主診醫生填寫(所需費用由索償人自行承擔)
TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON (AT THE CLAIMANT'S OWN EXPENSES)

1 病人姓名 Name of Patient _____

2 住院 Hospitalization

醫院名稱 Name of hospital _____

入院日期 Date of admission _____ 出院日期 Date of discharge _____

3 手術 Surgical operation

手術日期 Date of operation _____ 手術名稱 Name of operation _____

性質 Nature _____

4 此次住院/手術的主要病因 Chief complaints of the patient relating to this hospitalization/surgery

5 診斷 Diagnosis of conditions

6 出院摘要 (治療及以後治療計劃, 包括診查辦法、結果、併發症及跟進計劃)

Brief discharge summary (including treatments, investigation procedures, results, and/or any complications and follow up plan)

7 意外發生日期或首次出現病徵日期 Date of the accident occurred or symptom first appeared

8 病人首次求診日期 Date of first consultation for this condition or related illness

9 據閣下所知, 病人以前曾否患有同類病況?

To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto?

否
No

是 (請在下方列出詳情)
Yes (Please provide details at below)

日期和當時情況 _____
Dates and Details _____

10 病人是否經其他醫生轉介? Is the patient referred by another doctor?

否
No

是 (請在下方列出詳情)
Yes (Please provide details at below)

轉介醫生的姓名和地址 _____
Name and address of the referral doctor _____

主診/專科醫生的姓名 (資歷)
Name of Attending Physician/Specialist (with qualifications)

地址
Address

電話
Telephone

主診/專科醫生簽名及印鑑
Signature & Stamp of Attending Physician/Specialist

日期
Date

請把填妥的表格寄交九龍中央郵政局郵政信箱70302號宏利人壽保險(國際)有限公司。
Please return the completed form to Manulife (International) Limited, P.O. Box 70302, Kowloon Central Post Office.

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