

# Accident Dismemberment Claim - Attending Physician's Statement

## 意外傷殘賠償 – 醫生報告




Please print in **BLOCK** letters/ 請以**正楷**填寫

(To be completed by the attending Physician at the Claimant's Own Expenses. / 由主診醫生填寫，所需費用由索償人自行承擔。)

Policy No. 保單號碼		Name of Patient 病者姓名	
Occupation 職業		I.D. No. 身份証號碼	Date of Birth 出生日期
1. Medical History / 醫療紀錄			
(a) When and How did the accident happen? 意外日期及意外經過?		(a) (     /     /     ) MM/DD/YY 月/日/年	
(b) When did the patient ceased work because of disability? 病者何時開始因此傷殘而不能工作?		(b) (     /     /     ) MM/DD/YY 月/日/年	
(c) Has the patient ever had same or similar condition? 病者過往有否患上同類或類似之情況? If 'Yes', please state when and describe/ 若'是',請詳列患病日期及情況。		(c) Yes/是 <input type="checkbox"/> No/否 <input type="checkbox"/>	
(d) Is condition due to injury arising out of patient's employment? 病者之傷殘是否因其工作而引起?		(d) Yes/是 <input type="checkbox"/> No/否 <input type="checkbox"/>	
(e) Name(s) and address(es) of other attending Physicians/ 其他主診醫生姓名及地址			
Date 日期	Physician's Name or Hospital's Name 醫生姓名或醫院名稱		Address 地址
2. Diagnosis / 診斷			
(a) Date of first examination / consultation? 首次檢驗/求診日期?		(a) (     /     /     ) MM/DD/YY 月/日/年	
(b) Date of last examination / consultation? 最後檢驗/求診日期?		(b) (     /     /     ) MM/DD/YY 月/日/年	
(c) Diagnosis (Please state the part of the injured areas) 診斷(請詳述受傷部位)			
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(d) Was there any external and visible evidence of injury? If yes, please state the type of injury. 是否有外部及可見之損傷? 如是, 請詳述其受傷種類。			
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(e) Please describe the patient's Present Condition. What are the <b>degree and range of movement</b> of the injured areas? 請詳述病者之現時情況 (包括其受傷部位之移動程度及範圍)			
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3. Dates of Treatment / 治療日期			
(a) What kinds of treatment provided 治療種類	(a)	.....	
(b) Frequency 就診頻率	(b)	Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other(specify) <input type="checkbox"/>	.....
(c) The length of each treatment 每次就診需時	(c)	.....	
(d) Date of last treatment or scheduled 最後就診日期 (或安排中)	(d)	(     /     /     ) MM/DD/YY 月/日/年	

4. Did the patient require having any further operation or continuously treatment? If yes, please give details.

病者是否需要再次進行手術或接受長期治療？如是，請詳述。

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5. Physical Impairment (If applicable) 身體狀況(如適用)

- No Limitation of functional capacity; capable of heavy work. No restriction. 無任何功能之限制,可以作體力勞動。無限制。  
 Capable of medium manual activity. 可作中量之勞動。  
 Slight limitation of functional capacity; capable of light work. 輕度之功能受限,可作輕度工作。  
 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. 中度功能受限,可作文書工作。  
 Severe limitation of functional capacity; incapable of minimal (sedentary) activity. 重度功能受限,不能作任何工作。  
 Remarks: 其它

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6. Prognosis 預斷病情

(a) Did the injury result in any **Permanent Total Disablement or Total Loss of Use** of the injured areas involved?

(The term "Total Loss of Use" means a total functional disablement which is equivalent to the loss of said limb or organ)

就病者情況，其受傷之肢體是否**永久完全傷殘**或**永久完全喪失功能**?

(喪失功能是指完全失去活動功能，被視作完全喪失該肢體或器官)

Yes/是  No/否

- If YES, please state the part of permanent total loss of use or disablement. 若是，請詳述永久完全喪失功能或傷殘之位置。

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- If NO, please comment the chance and degree of recovery. 若否，請評論其復原之機會及程度。

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(b) Is the patient recover sufficiently to return to occupation? 病者是否已康復並回復工作? Yes/是  No/否

If NO, please comment when will the patient resume duty. 若否，請評論病者何時可恢復工作。

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(c) What duties of the patient's job is he/she incapable of performing? 在病者的工作中,他/她有何種職務不能執行?

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7. According to your opinion, any information will be assisting us in processing this claim? Please specify.

根據閣下的意見，**是否有**其他資料可以協助我們處理是次賠償? 請詳述。

8. Do you consent the FWD Medical Director and/or claim assessor to release the information provided by you in this report to the patient when we are requested by the patient to explain our claim decision?

閣下是否同意當病人有需要時，本公司之醫務人員或賠償批核員可透露閣下所提供之資料，以作解釋有關之賠償決定。

Signature and chop: \_\_\_\_\_ Date: \_\_\_\_\_  
醫生簽名及蓋章 日期

Name of Attending Physician: \_\_\_\_\_ Qualification: \_\_\_\_\_  
主診醫生姓名 學歷及資格

Address: \_\_\_\_\_ Telephone No.: \_\_\_\_\_  
地址 電話號碼