

危疾賠償申請表-自閉症 CRITICAL ILLNESS CLAIM FORM – AUTISM

保單號碼 Policy No.

第二部份 – 主診醫生報告書 (由主診醫生填寫，所有費用由受保人/保單持有人/索償人自行承擔)
PART II – ATTENDING PHYSICIAN'S STATEMENT (To be completed by attending physician at the Insured / Policyholder / Claimant's own expenses.)
A. 病人資料 PARTICULARS OF PATIENT

1 病人姓名 Name of Patient

2 年齡及性別 Age and Sex

3 身份證/ 護照號碼 I.D. Card / Passport No.

B. 臨床資料 CLINICAL DETAILS

1 病人之醫療記錄可追溯至 We can trace the medical record of patient back to

年 Year 月 Month 日 Day

2 首次出現病徵日期發生日期 Date of the symptoms first appeared

年 Year 月 Month 日 Day

3 病人首次有關此病症之求診日期 Date of first consultation for this condition or related illness

年 Year 月 Month 日 Day

4 請詳細說明首次會診時之徵狀和病症 Please describe the symptoms and complaints at first consultation.

 5 病人是否由其他醫生轉介？如是，請提供該醫生之姓名及地址。Is the patient referred by other physician? If yes, please give the name and address of the referring doctor. ☐ 是 Yes ☐ 否 No

6 診斷 Diagnosis

7 何時確診 When was the diagnosis made

年 Year 月 Month 日 Day

C. 閣下之專業意見 PROFESSIONAL COMMENT

 1 病人是否患有以下之嚴重的兒童精神障礙疾病，導致社交互動困難，語言、溝通和社會發展能力出現缺陷並出現下列情況
 Is the patient having severe emotional disturbance of childhood resulting in impairment in reciprocal social interaction and in communication, language and social development?

(I) 社交能力缺陷 Qualitative impairment of social interaction

 A. 在多種非語言行為方面出現顯著的缺陷。非語言行為包括使用眼對眼凝視，面部表情，身體姿勢及姿態等來調節社交互動；
 Marked impairment in the use of multiple types of non-verbal behavior such as eye to eye gaze, facial expression, body postures, and gestures to regulate social interaction;

☐ 是 Yes ☐ 否 No

B. 無法跟自己發育水平相若的人發展關係； Failure to develop peer relationships appropriate to developmental level;

☐ 是 Yes ☐ 否 No

C. 缺乏自我尋找與別人分享樂趣，興趣或成就的能力（例如：缺乏表現、帶出或指出感興趣的事物； Lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by lack of showing, bringing, or pointing out objects of interest);

☐ 是 Yes ☐ 否 No

D. 缺乏社交或感情的互動性 Lack of social or emotional reciprocity.

☐ 是 Yes ☐ 否 No

C. 閣下之專業意見 (續) PROFESSIONAL COMMENT (Continued)

(II) 溝通能力缺陷 Qualitative impairment of communication

A. 語言能力缺乏或發育遲緩 (沒有試圖通過其他的溝通模式, 如以肢體動作或以手勢來補充) Delay in, or lack of, development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gestures or mime);

☐ 是 Yes ☐ 否 No

B. 雖然有足夠語言能力, 但明顯缺乏與他人發起談話和維持談話的能力; In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others

☐ 是 Yes ☐ 否 No

C. 刻板地重覆使用同樣語句或怪癖的語句; 及 Stereotyped and repetitive use of language or idiosyncratic language; and

☐ 是 Yes ☐ 否 No

D. 較其同等發育水平程度的兒童, 缺乏有變化的假扮角色遊戲或模仿社交遊戲 Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

☐ 是 Yes ☐ 否 No

(III) 拘謹且刻板的行為、興趣及活動 Restrictive and stereotyped patterns of behavior, interests, and activities

A. 全神貫注于一種或多種的有限的、重覆的及刻板的興趣模式并顯得過度強烈及集中 All-encompassing preoccupation with one or more restricted, repetitive, and stereotyped patterns of interest that is abnormal either in intensity or focus

☐ 是 Yes ☐ 否 No

B. 呆板地遵循一些特定無意義的常規行為或儀式 Apparently inflexible adherence to specific, non-functional routines or rituals

☐ 是 Yes ☐ 否 No

C. 重覆的作出一些小動作 (例如: 手或手指上下或左右擺動或扭動、或整個身體移動不定) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements);

☐ 是 Yes ☐ 否 No

D. 持續性關注某物體的某部份 Persistent preoccupation with parts of objects

☐ 是 Yes ☐ 否 No

2 病人現時是否須進行以下治療 Does the patient currently require the following treatment(s)? 如是, 請提供開始日期 If so, please provide start date:

A. 病人的病況在診斷後不間斷地持續至少六個月

The patient condition have continued without interruption for a period of at least six (6) months after diagnosis, since

年 Year 月 Month 日 Day

B. 接受心理社會干預, 並提供開始日期:

The patient has started treatment of psychosocial interventions, since

年 Year 月 Month 日 Day

C. 特殊教育, 並提供開始日期:

The patient has started treatment of special education, since

年 Year 月 Month 日 Day

D. 行為治療, 並提供開始日期:

The patient has started treatment of behavior therapy, since

年 Year 月 Month 日 Day

請列出所有已開始接受心理社會干預和/或特殊教育和/或行為治療

Please list out all psychosocial inventions and/ or special education and/ or behavior therapy have carried out.

3 病人的病情是否與阿斯伯格綜合症和/或非典型自閉症有關? 如果是, 請提供詳細資料 Was the patient's condition related to Asperger Syndrome and/ or Atypical Autism? If so, please give details.

C. 閣下之專業意見 (續) PROFESSIONAL COMMENT (Continued)

- 4 請提供病人之前因此病症而求診的所有顧問、專家或醫院的姓名和地址。
Please give the name and address of all consultants, specialists or hospitals that had been attended by the Patient for this condition before.

- 5 病人現時進展及狀況? What was the prognosis of the patient?

- 6 如有，請提供有關是次治療、檢查及其結果、有否任何併發症及出院後之覆診或跟進計劃 If so, please provide treatments, investigation procedures, results, and/or any complications and follow up plan regarding the stroke)

D. 其他醫療病史 OTHER MEDICAL HISTORY

- 1 病人過往有否以下病症/習慣。 Does the patient have any medical history or habit as indicated below?

- | | | |
|---|---|---|
| ☐ 哮喘 Asthma | ☐ 心臟病 Cardiac problem | ☐ 糖尿病 Diabetes Mellitus |
| ☐ 乙型肝炎 Hepatitis B | ☐ 高血壓 Hypertension | ☐ 曾接受手術 Previous operation |
| ☐ 濫藥 Drug abuse | ☐ 飲酒習慣 Drinking | ☐ 吸煙習慣 Smoking |
| ☐ 家族性癌症 Family history of cancer | ☐ 家族病史 Unfavorable family history | |
| ☐ 以上皆沒有 None | ☐ 其他疾病，請說明 Other disease, please specify | |

- 2 該病人曾否因患上上述疾病或其他嚴重疾病接受醫生或醫院治療？如是者，請述詳情。 Had the patient previously been treated or hospitalized for the above disease or other major disease? If so, please give details.

日期 Dates			疾病 Disease	治療/住院詳情 Details of treatment/hospitalization	醫生姓名/醫院名稱 Name of Physician/Hospital
年 Year	月 Month	日 Day			

- 3 請提供飲酒/吸煙習慣詳情 Please provide details of Drinking & Smoking habit.

習慣始自 Drinking/ Smoking start date since 年 Year 月 Month 日 Day

每日用量 Daily consumption (支/包/樽/罐 piece/ pack/ bottle/ can)

E. 主診醫生資料及聲明 ATTENDING PHYSICIAN'S PARTICULARS AND DECLARATION

本人謹此聲明，就本人所知所信，上述由本人提供的資料均為事實之全部，並確實無訛。 I HEREBY DECLARE that all the information provided by me in this form is true and correct to the best of my knowledge and belief.

主診醫生姓名 Name of Attending physician		資歷 Qualification	
地址 Address		聯絡電話 Contact No.	
主診醫生簽署及醫院/診所蓋章 Signature of Attending Physician and Stamp of Hospital / Clinic		日期 Date	年 Year 月 Month 日 Day