

	<p>(iii) Extreme difficulty coping with change 極端困難應對變化 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>(iv) Great distress/difficulty changing focus or action 極大的困擾/難度去更改焦點或行動 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>C. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning 症狀造成臨床顯著的社會、職業或其他重要領域的功能障礙 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p>												
<p>6. Does the patient currently require the listed treatment(s)? If yes, please provide the start date and details. 病人現在是否進行所列的治療？如是，請提供開始日期及詳情。</p>	<p><input type="checkbox"/> Yes, provide the start date and details below 是，請提供開始日期及詳情 <input type="checkbox"/> No 否</p> <table border="0"> <thead> <tr> <th style="text-align: left;"><u>Types of Treatment 治療種類</u></th> <th style="text-align: left;"><u>Start Date 開始日期</u></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Behavioral Therapy 行為治療</td> <td>_____ / _____ / _____ (dd/mm/yyyy) (日/月/年)</td> </tr> <tr> <td><input type="checkbox"/> Occupational Therapy 職能治療</td> <td>_____ / _____ / _____ (dd/mm/yyyy) (日/月/年)</td> </tr> <tr> <td><input type="checkbox"/> Speech Therapy 語言治療</td> <td>_____ / _____ / _____ (dd/mm/yyyy) (日/月/年)</td> </tr> <tr> <td><input type="checkbox"/> Psychological Interventions 心理治療</td> <td>_____ / _____ / _____ (dd/mm/yyyy) (日/月/年)</td> </tr> <tr> <td><input type="checkbox"/> Special Education 特殊教育</td> <td>_____ / _____ / _____ (dd/mm/yyyy) (日/月/年)</td> </tr> </tbody> </table> <p>Please list out the details and institution(s) providing such treatments. 請列出有關詳情及提供治療的機構</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Since started the above intervention(s) does the patient continue to fulfil Level 3 Severity based on DSM-5 without interruption? If yes, please provide the latest copy of the report. 由開始上述治療至今，病人的情況是否繼續符合根據精神疾病診斷與統計手冊 (DSM-5) 所定嚴重程度 3 的標準？如是，請提供最新報告。</p> <p><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>Please describe the progress or responses of the patient from the above treatment or therapy provided. 請描述病人接受上述治療或療法後的進展或反應。</p> <p>_____</p> <p>_____</p> <p>_____</p>	<u>Types of Treatment 治療種類</u>	<u>Start Date 開始日期</u>	<input type="checkbox"/> Behavioral Therapy 行為治療	_____ / _____ / _____ (dd/mm/yyyy) (日/月/年)	<input type="checkbox"/> Occupational Therapy 職能治療	_____ / _____ / _____ (dd/mm/yyyy) (日/月/年)	<input type="checkbox"/> Speech Therapy 語言治療	_____ / _____ / _____ (dd/mm/yyyy) (日/月/年)	<input type="checkbox"/> Psychological Interventions 心理治療	_____ / _____ / _____ (dd/mm/yyyy) (日/月/年)	<input type="checkbox"/> Special Education 特殊教育	_____ / _____ / _____ (dd/mm/yyyy) (日/月/年)
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<p>7. What is the prognosis of the patient? 病人現時進展及狀況</p>													
<p>8. Do you know whether the patient was suffering from any other major, chronic or congenital disease? 你是否知道病人曾患有任何其他嚴重、慢性或先天性疾病？</p>	<p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否</p> <p>_____</p> <p>_____</p>												

<p>9. Please list details of all medical history (apart from what have mentioned above) that the patient had ever consulted you with. 請提供病人過去曾向你求診的所有醫療病歷詳情（除上述已提及外）。</p>	<p>Consultation date 求診日期</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Complaints/Symptoms 主訴 / 病徵</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Diagnosis 確診</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Treatment given 所提供治療</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>10. Was there any usual doctor of the patient other than you? 病人是否有其他慣常求診的醫生？</p>	<p><input type="checkbox"/> Yes (please provide name & address of the doctor) 是（請提供醫生姓名及地址） <input type="checkbox"/> No 否</p>			
<p>11. Any additional information you consider relevant to this claim. 其他與是次索償有關的資料。</p>				

Declaration 聲明

I hereby certify that I have personally examined and treated the patient in connection to the above condition and that the facts as given above present my opinion of his/her condition and all are true to the best of my knowledge and belief. I hereby declare that no information has been withheld by me at the request of the patient or his/her family.

本人謹此聲明曾親自為病人檢查及作出診治，以上填報的各項資料乃本人基於病人的情況而提供意見，所有答案，就本人所知所信，均為事實全部並確實無訛。本人在此聲明，沒有任何病人或其家屬要求本人隱瞞任何資料。

Name in block letters of Attending Physician / Specialist and Qualifications
主診 / 專科醫生姓名及資歷

Address and Contact No.
地址及聯絡電話號碼

Signature of Attending Physician / Specialist (with chop)
主診 / 專科醫生署名（蓋印）

Date (dd / mm / yyyy)
日期（日 / 月 / 年）