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在索取、列印或填寫表格前，請閣下先詳閱下文。

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## 免責聲明

閣下凡透過富通保險有限公司 [富通保險] 之電子收發渠道 [如公司網站、互動語音回應系統] 下載或列印任何表格，應自行考慮及衡量需承擔之風險。富通保險概不負責任何因下載或列印表格所引致的列印錯誤及其可能導致之任何損失或毀壞。若閣下提交之下載或列印表格有任何列印錯誤，富通保險有可能在處理閣下的申請前要求閣下填寫一份正確之表格。

當閣下填寫及簽署由網站下載之表格 [互聯網列印表格]，則被視作閣下已詳閱及明白電腦螢幕上出現之表格 [閱覽表格] 之內容，並同意表格內之所有條文。如該閱覽表格與互聯網列印表格出現任何不符、矛盾或分歧時，閣下同意並承諾不會提出任何異議。如閱覽表格與互聯網列印表格出現任何不符、矛盾或分歧時，概以閱覽表格為準。

富通保險有權隨時在認為適當情況下更新表格內容，並保留接受或拒絕閣下遞交之申請表格的權利。

# 預先保障審核安排服務申請書 Pre-Authorisation Service Application Form



如何申請住院免找數安排服務?  
How to apply for Inpatient Cashless Arrangement Service?

當確定需要住院或進行日間手術時，請根據情況進行以下步驟:

Once confinement or day-surgery needs are confirmed, please follow the instructions according to the applicable situation:

<p>1A</p> <p>OR 或</p>	<p><b>經網絡特選專科醫生轉介：</b>適用於「富通」醫療產品 登入「富通在線」於「E-ConNET 入院醫生搜尋」中選擇所需之網絡特選專科醫生，直接打電話給醫生預約症。 如果您有任何疑問，您可以致電 e 步通醫療服務熱線：(852) 2866 8898 「網絡特選專科醫生」為聯合醫務專業管理有限公司“UMP”網絡下的指定醫院或醫療服務機構。您可以不時向富通保險有限公司(「富通」)要求索取一份最新的網絡醫院及醫生名單。 當確定需要住院或進行日間手術時，網絡特選專科醫生會協助填寫本地住院免找數安排服務申請書(「表格」)的第三部份。 <b>When network doctor referral is needed:</b> Login to “Reach FTLife” and select e-ConNET Inpatient Doctor Search, select the doctor and call directly for the first consultation, if you have any queries, please contact the e-ConNET Medical Services hotline : (852) 2866 8898 “Appointed Network Specialist” refers to the doctors within the designated hospital or healthcare provider under the network of UMP Professional Management Limited (“UMP”). You may request from FTLife Insurance Company Limited (“FTLife”) for an updated list of the Appointed Network Hospital and Specialist from time to time.</p> <p>Once confinement or day-surgery needs are confirmed, the appointed network specialist would complete Part III of this Inpatient Cashless Arrangement Service Application Form (the “Form”).</p>
<p>1B</p>	<p><b>經非網絡特選專科醫生轉介，</b>直接到閣下之指定醫生處求診。只適用於「醫世保」、「裕醫保」、「御醫保特級」及「世逸」。當確定需要住院或進行日間手術時，請確保受保人的主診醫生正確填寫表格的第三部份。 <b>When no doctor referral is needed, consult the doctor of your choice directly. This service only applicable for MediPro, MediGold, MediGold Plus &amp; MediChamp.</b> Once confinement or day-surgery needs are confirmed, please ensure the attending doctor of the insured completes Part III of the form.</p>
<p>2</p>	<p>受保人或保單持有人需填妥表格的第一及第二部份。並於受保人住院或進行日間手術前最少四個工作天將表格遞交予 UMP。 Insured/ Policy Holder shall complete Part I and II of the form and send the form to UMP at least 4 working days prior to the insured's confinement or day surgery.</p>
<p>3</p>	<p>如您的申請成功 UMP 將向有關醫院或醫療機構發出「住院或日間手術付款保證書」並將確認信發送到您的電子郵件。If your application is successful UMP will issue a “Letter of Guarantee” to the relevant medical provider and send the confirmation letter to your email.</p> <p>*請注意：如醫療費用不超過我們據此表格批准之金額，於受保人完成日間手術後，網絡日間手術中心會將單據(「單據」)直接交給我們。在理賠手續辦妥後，您將會收到富通發出的賠償通知書。如有差額(定義見下文)及/或有每年自付額，富通將於賠償通知書發出後的 14 天內從您於表格的第二部份授權的信用卡帳戶中收取差額及/或自付額，如有。 *Please note: If the medical expenses do not exceed the amount we have approved under this Form, then upon the insured's completion of the day surgery, the Network Day case centre will send the invoice (the “Invoice”) directly to us. You will receive a claims statement after the claim is processed. If there is any Shortfall (as defined below) &amp;/or any balance of annual deductibles, FTLife will arrange for settlement of the Shortfall including the balance of deductibles by debiting from the credit card you have authorized in Part II of the Form within 14 days after the claims statement is dispatched.</p>

## 免找數安排服務之條款及條件：

### Terms and Conditions for Cashless Arrangement Service:

- i) 免找數安排服務不適用於以下醫療費用：  
No Cashless Arrangement Service will be provided for medical expenses that are:
  - a) 超出我們就此表格所批准的金額的費用，或  
in excess of the amount we have approved under this Form, or
  - b) 您的保單(「該保單」)內界定之保單生效日期或復效日(以後者為準)後的首一百八十日內產生的費用；或  
incurred within the first 180 days after the Policy Effective Date as defined in your insurance policy (the “Policy”) or the date of reinstatement (whichever is later); or
  - c) 不符合醫療必要或合理及慣常費用定義之費用；或  
the expense which does not meet the definition of Medically Necessary or Reasonable and Customary Charges; or
  - d) 過去免找數安排服務下之逾期差額(如有)；或  
overdue shortfall from previous cashless arrangement (if any); or
  - e) 未在表格上申報之手術費用；或  
the surgical expense which has not yet been declared on the Form; or
  - f) 不受該保單保障的費用。  
not covered by the Policy.
- ii) 由於我們是根據對醫學療程的估計批核您的免找數安排服務申請；故此，該批核並不代表我們對您的索償的所有項目均已批核或將會批核。我們保留權利在審閱單據後拒絕您的索償，並追回我們已付但在該保單的保障範圍內的醫療費用(「差額」)，以及應繳付之每年自付額(如有)。  
Since our approval of your application for Cashless Arrangement Service is based on an estimation of the course of medical treatment, that approval does not mean that we have approved or will approve all items of your claim. We reserve the right to reject your claim upon evaluation of the Invoice, and recoup the part of the medical expenses which we have paid but is not covered by the Policy (the “Shortfall”) & payable annual deductibles (if any).
- iii) 您須提供醫療詳情，並授權富通由您的信用卡戶口收取差額，以及應繳付之每年自付額(如有)。  
You will be required to provide details of medical treatment and authorize FTLife to collect the Shortfall & payable annual deductibles (if any) from your credit card account.
- iv) 富通對免找數安排服務引起的一切事項擁有唯一及絕對決定權。  
FTLife has the sole and absolute discretion in relation to all matters arising from the Cashless Arrangement Service.
- v) 富通保留終止或變更免找數安排服務的權利而無須另行通知。  
FTLife reserves the right to terminate or vary the Cashless Arrangement Service in our sole discretion without further notice.

# 預先保障審核安排服務申請書

## Pre-Authorisation Service Application Form



保單號碼  
Policy Number

保險代理 / 經紀姓名  
Name of Agent / Broker  
保險代理 / 經紀編號  
Code of Agent / Broker  
電話  
Telephone No.


請於填寫此表格前細閱「如何申請住院免找數安排服務」的部份。請填妥此表格並於住院或進行日間手術前最少四個工作天，以傳真(852) 3468 2603 或電郵 FTLife.PA@ump.com.hk 方式遞交予聯合專業管理有限公司。  
Please read the section on "How to apply for Inpatient Cashless Arrangement Service?" and the Terms and Conditions for Cashless Arrangement Service before completing this Form. Please send the completed Form to FTLife Insurance Company Limited by fax (852) 3468 2603 or e-mail FTLife.PA@ump.com.hk at least 4 working days prior to confinement or day surgery.

<b>第一部份-由受保人或保單持有人填寫</b> <b>Part I - To be completed by Insured / Policy Owner</b>		
<b>A. 受保人及保單持有人個人資料 Personal Particulars of the Insured and Policy Owner</b>		
1. 保單持有人姓名 Name of Policy Owner	2. 受保人姓名 Name of Insured	3. 受保人身份證 / 護照號碼 Insured's ID / Passport No.
4. 受保人年齡 Age of Insured	5. 受保人性別 Sex of Insured	6. 保單持有人電話號碼 Telephone No. of Policy Owner
		7. 保單持有人電郵地址 E-mail Address of Policy Owner
<b>請根據是次住院或日間手術之原因填寫 B 或 C 部分 Please fill in part B or C according to the reason of confinement or day surgery</b>		
<b>B. 如住院或日間手術是疾病引致 If Confinement or Day Surgery is due to Illness</b>		
1. 住院或進行日間手術前有何等徵狀? What are the symptoms presented before confinement or day surgery?		2. 首次就診之前, 受保人有此等徵狀已多久? How long has the Insured been having these symptoms before the first consultation?
3. 何時因此等徵狀而首次求診 (日/月/年)? When did the first consultation for these symptoms (DD/MM/YY) take place?		
4. 就診詳細情況及其他資料 Details of Consultation and Other Information		
a. 首次就診疾病或受傷診治受保人的醫生的名稱和地址: Name and address of the doctor who first treated the insured for the injury or the illness:	b. 建議受保人入院的醫生的名稱和地址: Name and address of the doctor who referred the insured to hospital:	c. 過往就同樣病症曾向其求診的醫生名稱和地址: Name and address of doctors consulted in the past for similar condition:
<b>C. 如住院或日間手術是意外引致 If Confinement or Day Surgery is due to Accident</b>		
1. a. 意外日期 (日/月/年): Date of accident (DD/MM/YY):		2. a. 意外如何發生? How did the accident happen?
b. 意外發生的時間: Time of accident:		b. 有否報警? Has the accident been reported to the police? <input type="checkbox"/> 否 No <input type="checkbox"/> 有 Yes
c. 意外發生的地點: Place of accident:		c. 如有, 請附上口供紙或警察報告影印本 If yes, please attach a photocopy of the witness statement or police report
3. 身體的哪些部位受傷? Which parts of the body were injured?		4. 受傷程度如何? What was the extent of the injury?
5. 就診詳細情況及其他資料 Details of Consultation and Other Information		
a. 首次就診疾病或受傷診治受保人的醫生的名稱和地址: Name and address of the doctor who first treated the insured for the injury or the illness:	b. 建議受保人入院的醫生的名稱和地址: Name and address of the doctor who referred the insured to hospital:	c. 過往就同樣病症曾向其求診的醫生名稱和地址: Name and address of doctors consulted in the past for similar condition:

# 預先保障審核安排服務申請書

## Pre-Authorisation Service Application Form



<b>第二部份-由受保人或保單持有人填寫</b> <b>Part II - To be completed by Insured / Policy Owner</b>		
<b>A. 收取差額及/或應繳付之每年自付額之信用卡授權書 Credit Card Authorization Form for Shortfall &amp;/or Payable Annual Deductibles (if any) Collection</b>		
<p>如富通向醫院支付的費用超出該保單的保障範圍，此授權書將授權富通從以下的信用卡帳戶收取差額及/或應繳付之每年自付額（如有）。信用卡持卡人可以是該保單之保單持有人、受保人、受益人，或保單持有人/受保人之直系親屬，包括父母/配偶/子女/兄弟姊妹/祖父母/孫子女/配偶的父母/子女的配偶。富通將於信用卡保留港幣 50,000 元，直至整個理賠程序完結為止。富通將於收取差額的十四天前向保單持有人發出差額付款通知書。（請注意，就香港客戶而言，我們會接受 VISA, MASTER CARD 及 American Express）</p> <p>In the event that the Company has settled any charges not covered by the Policy, this Part authorizes FTLife to collect the Shortfall &amp;/or payable annual deductibles (if any) by debiting from the following credit card account. The credit card holder can be the Policy Owner, the insured, beneficiary or close relative of policy owner / life insured including parent / spouse / children / siblings / grandparent / grandchild / parent-in-law / son-in-law / daughter-in-law. FTLife will hold HKD 50,000 from the credit limit of this credit card account until the claim assessment is fully completed. The shortfall notification will be sent to Policy Owner 14 days prior to collection. (Please note that for Hong Kong customers, Visa Card, Master Card and American Express Card are acceptable)</p>		
信用卡付款授權書 Credit Card debit authorization (此部分必須填寫 this section must be completed)		
持卡人姓名 Cardholder's Name:	持卡人身份證 / 護照號碼 Cardholder I.D. Card/Passport No.:	持卡人與受保人的關係 Relationship with Policyowner/Insured:
信用卡號碼 Credit Card Account No.:	信用卡到期日 Credit Card Expiry Date:	
本人授權及指示富通如本第二部份上文所述，從本人的信用卡戶口的信用額保留港幣 50,000 元及從其扣除差額及/或應繳付之每年自付額 I hereby authorize and direct FTLife to hold HKD 50,000 from the credit limit of and debit the Shortfall &/or payable annual deductibles (if any) from my credit card account as detailed above in this Part II.		
持卡人簽署 Cardholder's Signature:		聯絡電話 Contact no.:
日期(日/月/年) Date (DD/MM/YY):		
<b>B. 住院醫療諮詢服務 "Inpatient Advice" service preference:</b> 住院醫療諮詢服務將提供予經醫生確診而需要住院進行治療的受保人。這是為受保人提供的增值服務，可就有關確診的疾病得到進一步意見。住院醫療諮詢服務可以下列不同形式進行及由不同國家醫生提供，請選擇其中 1 項： Inpatient Advice service would be provided to insured who have an inpatient recommendation regarding the diagnosis made by a medical doctor. This is a value-added service for the insured to obtain extra information about the diagnosis in different forms and provided by doctors of different countries listed below. Please choose ONE item from the below options:		
<input type="checkbox"/> 不需要住院醫療諮詢服務 No Inpatient Advice service needed	<input type="checkbox"/> 需要香港住院醫療諮詢服務, In-patient Medical Advice service needed 1. <input type="checkbox"/> 專科醫生診症 Specialist consultation 2. <input type="checkbox"/> 書面報告 Written report 3. <input type="checkbox"/> 遠程視訊諮詢 Tele-consultation	
如選擇使用住院醫療諮詢服務，本人將授權聯合專業管理有限公司("UMP") 收集本人之醫療報告及住院建議作醫療轉介用途。所收集的資料絕對保密，及在諮詢服務完成後三個月內銷毀。一切資料由授權人自願提供並自行選擇最終治療決定。聯合專業管理有限公司並不會為任何治療決定、過程及其治療結果負責。 <p>By choosing to use the Inpatient Advice service, I hereby authorize UMP Professional Management Limited ("UMP") to collect my medical reports and materials relevant to the inpatient recommendation for referral purpose. Information collected will be kept confidential and would be destroyed after 3 months upon completion of the service. All information is provided voluntarily and all treatment decisions are made by the authorizer.</p>		

<b>收集個人資料聲明 Personal Information Collection Statement</b>
<p>本人 / 我們確認本人 / 我們已閱讀及明白富通保險有限公司（以下簡稱“富通保險”）之個人資料收集聲明（“該聲明”）。本人 / 我們聲明及同意貴公司可根據該聲明所述的任何目的收集及 / 或持有、使用及/或披露/分享任何個人資料（不論是從此表格或以其他方式獲得）。本人 / 我們明白本人 / 我們必須於此表格提供所須資料，否則貴公司將可能無法執行該聲明之目的及 / 或向本人 / 我們提供產品或服務。本人 / 我們確認及同意本人 / 我們的個人資料可能披露/共享給該聲明所指明的第三方；執法機構；保險業就現有資料而對所提供的資料作出分析和檢查而使用的數據庫或登記冊作出於該聲明所述的任何目的。本人/我們明白該聲明的最新版本可於富通保險的網址下載：www.ftlife.com.hk，及可向貴公司索取。</p> <p>I /We confirm that I/we have read and understood FTLife Insurance Company Limited ("FTLife")'s Personal Information Collection Statement ("PICS"). I/We declare and agree that any personal data FTLife may collect and/or hold, use and/or disclose/share with (whether contained in this form or otherwise obtained) in accordance with the Purposes as set out in the PICS. I/We understand that if I/we do not provide the required personal data, FTLife may not be able to perform the Purposes and/or provide products or services to me/us. I/We acknowledge and agree that my/our personal data may be disclosed/shared with specified parties in the PICS; law enforcement authorities; databases or registers used by the insurance industry to analyse and check information provided against existing information for any of the Purposes stated in the PICS. I/We understand the updated version of the PICS is available for download from FTLife's website: www.ftlife.com.hk, and will be made available upon request.</p>



# 預先保障審核安排服務申請書

## Pre-Authorisation Service Application Form



**聲明及授權書** (由保單持有人及受保人簽署, 如受保人未滿 18 歲, 則由其家長或合法監護人簽署)。

**Declaration and Authorization** (To be signed by the policyowner and insured OR to be signed by the insured's parent / legal guardian if the insured is under the age of 18).

本人/我們聲明上述一切陳述及對問題的所有答案均為事實之全部, 並確實無訛。

I/We declare that the above statements and answers made by me/us are true, accurate and complete.

本人/我們茲授權凡知道或擁有任何有關本人或受保人記錄的僱主、任何註冊西醫、醫院、診所、保險公司、其他機構或人士, 均可將該等資料提供給富通保險有限公司。即使本人或受保人死亡或喪失能力, 此授權書仍然有效, 所有本人及受保人之繼承人及承讓人亦會受此授權書約束。本授權書的影印本與正本具有同等效力。

I/We hereby authorize any employer, any registered medical practitioner, hospital, clinic, insurance company or other institution or person, that has any records or knowledge of me or the Insured named to give such information to FTLife Insurance Company Limited. This authorization shall bind the successors and assignees of me/the Insured and remain valid notwithstanding the death or incapacity of me/the Insured. A photocopy of this authorization shall be as valid as the original.

本人 / 我們明白及同意 I/We understand and agree that:

- 遞交此住院免找數安排服務申請書或由貴公司簽發付款保證信均不得被詮釋為等同於貴公司承擔賠償責任。  
Neither submission of this Inpatient Cashless Arrangement Service Application Form nor the issuance of letter of guarantee by the Company shall be construed as admission of liability on the part of the Company.
- 若貴公司曾支付任何不在該保單的受保障範圍內的費用 (如: 應繳付之每年自付額), 貴公司將從第二部份指定的信用卡中扣除差額。若貴公司因任何原因包括但不限於有關信用卡戶口的信用額不足, 以至未能收取該筆差額, 貴公司將有權把差額從貴公司據該保單及/或任何由貴公司簽發的保單所應支付予該保單的保單持有人的任何金額中抵銷扣除, 包括但不限於任何身故賠償 (在法律允許的範圍內)、紅利或保費退還 (不論任何原因), 不論該保單的保單持有人本來是否將以一份保單的擁有人的身份有權獲得該等金額。  
In the event that the Company has settled any charges not covered by the Policy, i.e. any payable annual deductibles, the Company shall deduct the Shortfall from the credit card as specified in Part II. However, if collection of the Shortfall is unsuccessful due to any reasons including but not limited to insufficient funds in the credit card account, the Company shall have the right to offset the Shortfall against any amount due or payable to the Policy Owner from the Policy and /or any policy issued by the Company including but not limited to any death benefit (to the extent it is permissible by law), dividends or return of premium (for whatever reason), irrespective of whether the Policy Owner is otherwise entitled to receive that amount in the capacity of a policy owner.

本人/我們明白若此免找數安排服務申請書的中、英文兩個版本有任何抵觸或不相符之處, 應以英文版本為準。

I/We understand that if there is any inconsistency or ambiguity between the English version and the Chinese version of this Cashless Arrangement Service Application Form, the English version shall prevail.

保單持有人簽署  
Signature of Policy Owner : x \_\_\_\_\_

見証人簽署  
Signature of Witness : x \_\_\_\_\_

保單持有人姓名 (大寫)  
Name of Policy Owner (in block letters) : \_\_\_\_\_

見証人姓名 (大寫)  
Name of Witness (in block letters) : \_\_\_\_\_

身份證 / 護照號碼  
ID / Passport No. : \_\_\_\_\_

日期 (日/月/年)  
Date (DD/MM/YY) : \_\_\_\_\_

日期 (日/月/年)  
Date (DD/MM/YY) : \_\_\_\_\_

受保人簽署 (年齡十八歲或以上必須簽署)  
Signature of Insured (whose age is 18 or above): x \_\_\_\_\_

If the insured is under the age of 18, please provide the following information:

受保人姓名 (大寫)  
Name of Insured (in block letters) : \_\_\_\_\_

身份證 / 護照號碼  
ID / Passport No. : \_\_\_\_\_

日期 (日/月/年)  
Date (DD/MM/YY) : \_\_\_\_\_

# 預先保障審核安排服務申請書

## Pre-Authorisation Service Application Form



第三部份 - 由受保人的主診醫生填寫(費用由保單持有人支付)

Part III - To be completed by the Attending Doctor of the Insured (Cost to be borne by Policy Owner)

1. a. 病人姓名 Name of patient	b. 身份證/護照號碼 ID / Passport No.	c. 年齡/性別 Age / Sex	d. 職業 Occupation
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### 醫療詳情 Medical Condition

1. 求診時之病徵或不適： The symptoms/complaints on the date of the consultation: 原因Cause: <input type="checkbox"/> 疾病 Illness <input type="checkbox"/> 受傷 Injury	
2. 病徵或不適首次出現之日期 (日/月/年)： Date on which symptoms/complaints first appeared (DD/MM/YY):	
3. 診斷 Diagnosis	4. 國際疾病分類編號 ICD code
5. 首次診斷日期： First consultation date:	
6. 該情況是否以下其中之一(請選擇)？ Is this condition any one of the following (Please choose?) <input type="checkbox"/> 慢性疾病之初次病發 first episode of a chronic illness? <input type="checkbox"/> 慢性疾病的再次病發 recurrent episode of a chronic illness? <input type="checkbox"/> 以上全部皆否 "No" to all of the above 如其中的項目為「是」，請提供該項的資料 If one of the above is "Yes", please give details:	
7. 首次發病日期 (日/月/年)： Onset of the first episode (DD/MM/YY) :	
8. 有關疾病或受傷是否由以下因素導致？ Was such illness or injury caused by the following factors? 有 Yes 否 No <input type="checkbox"/> <input type="checkbox"/> 自致傷害 (原因及經過) Self-inflicted injury (How it happened & underlying cause) <input type="checkbox"/> <input type="checkbox"/> 酗酒及濫用藥物 (酒類/藥物名稱、份量及飲食/服食多久) Drug abuse and Alcohol abuse (Name & dosage of drug/alcohol, quantity and duration of consumption) <input type="checkbox"/> <input type="checkbox"/> 退化性轉變 (發病日期及求診詳情) Degenerative changes (Onset date & consultation details) <input type="checkbox"/> <input type="checkbox"/> 先天性缺陷 (診斷、發病日期及求診詳情) Congenital anomalies (Diagnosis, date of onset & details of consultation) <input type="checkbox"/> <input type="checkbox"/> 過往受傷/疾病 (原因及求診詳情) Past injury or illness (Cause and details of consultation) <input type="checkbox"/> <input type="checkbox"/> 不育、絕育、懷孕、分娩或流產 (與疾病或受傷的關係及詳情) Infertility, Sterilization, Pregnancy, Childbirth or Miscarriage (How it related to the Illness or injury and details) <input type="checkbox"/> <input type="checkbox"/> 精神病 (發病日期及求診詳情) Psychiatric condition (date of onset & details of consultation) <input type="checkbox"/> <input type="checkbox"/> 肥胖,體重控制(發病日期及求診詳情) Obesity, weight control (date of onset & details of consultation) 若「是」，請詳述。 If yes, please give details:	
9a. 請列出受保人為此住院或日間手術需接受的全部化驗/診斷掃描/其他診斷性檢查及進行該等檢查的原因 Please list out all laboratory tests/diagnostic imaging/other diagnostic investigations required for this Confinement or Day Surgery and reasons for conducting the same. 是次檢查及治療可否在門診處理,而無須在醫院進行? Can the treatment and the medical test(s) be managed under an out-patient setting instead? <input type="checkbox"/> 可以 Yes <input type="checkbox"/> 不可以 No 若可以在門診處理,請說明病人住院的原因。 If "Yes", why was the patient admitted to hospital? 若不可以門診處理,請詳述之。 If "No", please give details.	

# 預先保障審核安排服務申請書

## Pre-Authorisation Service Application Form



<p>9b. (若計劃住院) 就病人的病況，病人是否可以在門診進行所建議的治療/化驗/診斷掃描/其他診斷性檢查等？ (If confinement is contemplated) Given the condition of the patient, is it possible to provide the suggested treatment/laboratory test/diagnostic imaging/other diagnostic investigation etc. on an outpatient basis?  <input type="checkbox"/> 是 Yes <span style="margin-left: 200px;"><input type="checkbox"/> 否 No</span></p> <p>如「否」，請提供原因。If "No", please explain.</p>
<p>10. 手術前後診症 Pre/Post-Consultation (For UMP Panel Doctor)</p> <p>1. 手術前診症 Pre-Consultation 診金Fee: \$ _____ (診症次數：一次 No. of consultation: 1 time)</p> <p>2. 手術後診症 Post-Consultation 診金Fee: \$ _____ (診症次數：一次 No. of consultation: 1 time)</p>
<p>11. 手術 Surgical Procedure</p> <p>手術日期 (日/月/年) : _____ Date of Operation (DD/MM/YY) : _____</p> <p>手術名稱 : _____ Name of Operation : _____</p> <p>外科醫生之姓名 : _____ Surgeon's name : _____</p>
<p>12. 麻醉 Anaesthesia: <input type="checkbox"/> 全身麻醉 General Anaesthesia <input type="checkbox"/> 局部麻醉 Local Aneasthesia</p>
<p>13 a. 醫院名稱/日間手術中心 : _____ Name of hospital / day surgery centre: _____</p> <p>b. 預計入院日期 (日/月/年) : _____ Estimated date of admission (DD/MM/YY) : _____ 預計住院日數 (日數) : _____</p> <p>Estimated length of stay (number of days) : _____ 就你所知，該種情況/手術所需的住院日數為 : _____ To the best of your knowledge, what is the usual length of stay for the similar condition and surgery? _____</p> <p>住房級別: <input type="checkbox"/> 普通病房 <input type="checkbox"/> 半私家房 <input type="checkbox"/> 標準私家房 Room Level: Ward Semi-Private Standard Private</p>
<p>14. 預計是次住院或進行日間手術下列各項費用 Estimated fee for the following items under this Confinement or Day Surgery:</p> <p>a. 醫生費 Daily Attendance Fee : _____ b. 專科醫生費 Specialist Fee: _____</p> <p>c. 手術費 Surgical Fee: _____ d. 麻醉費 Anaesthetic Fee: _____</p> <p>e. 藥物 medication fee: _____</p> <p>f. 其他醫院費用 Other miscellaneous expenses _____</p>
<p>15. 請列出建議之化驗/影像檢查/其他診斷性檢查及接受該等檢查的原因。 Please list out any Lab tests / Imaging / other diagnostic investigations required for this hospitalisation and reasons for the same.</p> <p>該等檢查是否僅在醫院可有? 若不可以,請詳述之。 Are the investigations available only in hospital? If "No", please give details.</p> <p>該檢查及手術可否在門診 / 日間手術中心進行? Can the medical test(s) and the procedure be done on an outpatient basis/at day surgery centre?</p>
<p>16. 這是否緊急個案? Is it a case of emergency?</p> <p><input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No</p> <p>如是，請明確說明。 If yes, please specify.</p>
<p><b>醫生聲明及簽署 Doctor's Declaration and Signature</b></p> <p>本人謹此證明本人已親自為病人就上述之病症或受傷進行檢查，並確認以上提供的有關病人現時及過去的情況的資料就本人所知所信屬實。 I hereby certify that I have personally examined the patient and attended to his/her illness or injury, and that the information about his current and past condition as stated above is true to the best of my knowledge and belief.</p> <p>主診醫生姓名 (專業資歷) _____ 簽署 (及印章) _____ Name of Attending Doctor (with qualification) _____ Signature (with chop) _____</p> <p>地址及電話號碼 _____ 日期 (日/月/年) _____ Address &amp; Phone No. _____ Date (DD/MM/YY) _____</p>