From :
Dr._____

To: Employees' Compensation Division Labour Department

Medical Report for Employees' Compensation

I. Personal Particulars:

Name of patient: _____ **中文姓名:** _____

Sex: □**Male** □ **Female** **Age:**_____ **ID No.:** _____

Date of accident: _____

II. Details of Consultation

Medical Record Reference No.: _____

The above mentioned patient first attended _____ **Clinic (private practice)**

at _____ **(Time) on** _____ **(Date)**

Referral: □**Yes** □ **No** **From:** _____

History of injury at work: □**Yes** □ **No (please specify)** _____

Brief summary of clinical features and history: _____

_____

Condition: □ **likely related to the alleged accident** □ **unlikey related to the alleged accident**

□ **others – please specify:** _____

III. Past medical and surgical history:

_____

The above condition was a replase of past medical and surgical condition (please specify)

□ **No** □ **Yes** _____ □ **Others:** _____

IV. Treament given:

_____

Referral to other units for management: □ **No** □ **Yes** _____ _____

Sick leaves given for the above presenting condition (Please specify the dates/period(s)):

_____

Expected permanent impairment: □ **No** □ **Yes**

Static physical condition for assessment: □ **No** □ **Yes** □ **Not yet until** _____

Name of doctor : _____

Signature : _____

Clinic Chop : _____ **Date** : _____

Clinic Address & Telephone : _____