

乙部 - 危疾 - 癌症 / 早期癌症 / 原位癌

PART II – CRITICAL ILLNESS – CANCER / EARLY STAGE MALIGNANCY / CARCINOMA-IN-SITU

(由主診醫生填寫，所需費用由索償人自行承擔。 TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON AT THE CLAIMANT'S OWN EXPENSES)

病人姓名 Name of Patient	年齡及性別 Age & Sex	身份證號碼 ID No.	職業 Occupation								
1. 你是否病人慣常求診的醫生? Are you the patient's usual attending physician?	<input type="checkbox"/> 是 YES <input type="checkbox"/> 否 NO 醫療紀錄自 Medical records since _____ (年/月/日) (YY/MM/DD)										
2. 病人是否由其他醫生轉介? Was the patient referred by another physician?	<input type="checkbox"/> 是 YES <input type="checkbox"/> 否 NO 轉介醫生的姓名和地址 Name and address of the referral physician _____										
3. 病人因是次疾病的首次求診日期 Date of first consultation for this illness	_____ (年/月/日) (YY/MM/DD)										
4. 首次求診的病徵及病徵出現日期 Symptoms presented and date of onset during the first consultation	病徵 Symptoms _____ 病徵出現日期 Symptoms Onset Date _____ (年/月/日) (YY/MM/DD)										
5. 診斷結果 Diagnosis of conditions											
6. 診斷日期 Date of diagnosis	_____ (年/月/日) (YY/MM/DD)										
7. 病人何時被告知有關疾病的診斷? When was the patient informed of the diagnosis?	日期 Date _____ (年/月/日) (YY/MM/DD) 醫生姓名 Name of physician _____										
8. 病人曾否患有相關疾病? Has the patient previously suffered from related condition of this illness?	<input type="checkbox"/> 是 YES, 請提供詳情 Please provide details <input type="checkbox"/> 否 NO <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;"><u>日期</u></td> <td style="width: 25%;"><u>醫生/醫院名稱</u></td> <td style="width: 25%;"><u>診斷</u></td> <td style="width: 25%;"><u>治療詳情</u></td> </tr> <tr> <td><u>Date</u></td> <td><u>Name of Physician/Hospital</u></td> <td><u>Diagnosis</u></td> <td><u>Treatment Details</u></td> </tr> </table>			<u>日期</u>	<u>醫生/醫院名稱</u>	<u>診斷</u>	<u>治療詳情</u>	<u>Date</u>	<u>Name of Physician/Hospital</u>	<u>Diagnosis</u>	<u>Treatment Details</u>
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9. 病人是否因任何家族病史或其他因素促使增加患上此疾病的機會? Is there any patient's family history or any precipitating factors which would have increased the risk of this illness?	<input type="checkbox"/> 是 YES, 請提供詳情 Please provide details <input type="checkbox"/> 否 NO										
10. 請提供此疾病的所有求診記錄及治療詳情。 Please provide all the consultation history and details of this illness.	<table style="width: 100%; border: none;"> <tr> <td style="width: 25%;"><u>日期</u></td> <td style="width: 25%;"><u>醫生/醫院名稱</u></td> <td style="width: 25%;"><u>診斷</u></td> <td style="width: 25%;"><u>治療詳情</u></td> </tr> <tr> <td><u>Date</u></td> <td><u>Name of Physician/Hospital</u></td> <td><u>Diagnosis</u></td> <td><u>Treatment Details</u></td> </tr> </table>			<u>日期</u>	<u>醫生/醫院名稱</u>	<u>診斷</u>	<u>治療詳情</u>	<u>Date</u>	<u>Name of Physician/Hospital</u>	<u>Diagnosis</u>	<u>Treatment Details</u>
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<p>11. 請提供此疾病的詳情: Please provide the details of this illness:</p> <p>(a) 腫瘤的確定位置 What is the site of the Tumor?</p> <p>(b) 腫瘤被界別為第幾級別? What is the staging of the Tumor?</p> <p>(c) 是否屬原位癌? Was it Carcinoma -in-situ?</p> <p>(d) 腫瘤是否完全在位生長? Was the Tumor completely localized?</p> <p>(e) 惡性細胞是否不受控制地生長及蔓延? Was there uncontrolled growth of malignant cells?</p> <p>(f) 腫瘤是否已浸潤至其他鄰近細胞或淋巴? Was there any invasion of adjacent tissue or regional lymph node?</p> <p>(g) 腫瘤是否轉移到其他身體器官? Was there distant metastasis to other organ(s)?</p> <p>(h) 診斷是否經病理分析確定? (請提供病理分析報告) Is the diagnosis confirmed with histological examination? (Please provide the histological report.)</p>	<p>(a) _____</p> <p>(b) 級別 Staging _____ 級別分類 Staging System _____</p> <p>(c) <input type="checkbox"/> 是 YES <input type="checkbox"/> 否 NO</p> <p>(d) <input type="checkbox"/> 是 YES <input type="checkbox"/> 否 NO</p> <p>(e) <input type="checkbox"/> 是 YES <input type="checkbox"/> 否 NO</p> <p>(f) <input type="checkbox"/> 是 YES <input type="checkbox"/> 否 NO</p> <p>(g) <input type="checkbox"/> 是 YES <input type="checkbox"/> 否 NO</p> <p>(h) <input type="checkbox"/> 是 YES, 請提供詳情 Please provide details <input type="checkbox"/> 否 NO 日期 Date 病理分析類別 Type of histological examination performed 結果 Result</p> <p>若未有進行病理分析, 原因為何? What is the reason if histological examination is not done?</p>						
<p>12. 所有診斷檢驗的詳情及結果。 (請提供所有診斷及化驗報告) Details of all diagnostic tests performed and the result. (Please enclose copies of all diagnostic test and laboratory reports.)</p>	<table border="1"> <thead> <tr> <th>檢驗日期 Test Date</th> <th>檢驗項目 Test Item</th> <th>結果 Result</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	檢驗日期 Test Date	檢驗項目 Test Item	結果 Result			
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<p>13. 如診斷為白血病, 請提供確實白血病之類別詳情。 If the diagnosis is Leukaemia, please advise the type and details of Leukaemia.</p>							
<p>14. 如診斷為皮膚癌, 是否屬惡性黑色素瘤? If the diagnosis is Skin Cancer, was it malignant melanoma?</p>	<p><input type="checkbox"/> 是 YES, 請提供活組織檢查報告及結果 Please provide the biopsy report and result <input type="checkbox"/> 否 NO</p>						
<p>15. 治療詳情 Treatment Details</p>	<p><input type="checkbox"/> 電療 Radiotherapy <input type="checkbox"/> 化療 Chemotherapy <input type="checkbox"/> 舒緩治療 Palliative</p> <p><input type="checkbox"/> 手術 Surgical 手術名稱 Name of Surgery _____</p> <p><input type="checkbox"/> 其他, 請註明 Others, please specify _____</p>						
<p>16. 病人過往有否右列之病歷/ 習慣? Has the patient ever had the medical illness(es) or the habit(s) as listed on the right column?</p>	<p><input type="checkbox"/> 否 NO</p> <p><input type="checkbox"/> 是 YES, 請在適當位置劃上剔號並提供詳情 Please tick where it is appropriate and give details</p> <p><input type="checkbox"/> 心臟病 Cardiac problem</p> <p><input type="checkbox"/> 高血壓 Hypertension</p> <p><input type="checkbox"/> 高血脂 Hyperlipidaemia</p> <p><input type="checkbox"/> 糖尿病 Diabetes mellitus</p> <p><input type="checkbox"/> 乙型肝炎 Hepatitis B</p> <p><input type="checkbox"/> 人類免疫力缺乏病毒感染 HIV infection</p> <p><input type="checkbox"/> 曾接受手術 Previous operation</p> <p><input type="checkbox"/> 濫用藥物 Drug addiction</p> <p><input type="checkbox"/> 吸煙習慣 Smoking habit</p> <p><input type="checkbox"/> 飲酒習慣 Drinking habit</p> <p><input type="checkbox"/> 其他嚴重、慢性或先天性疾病 Other major, chronic or congenital illness _____</p> <p>詳情 Details: 診斷日期及醫生名稱 Diagnosis date and name of physician _____</p> <p>病歷之現況 Current condition of the above medical history <input type="checkbox"/> 完全康復 Fully recovered <input type="checkbox"/> 治療中 On Treatment _____</p> <p>吸煙/飲酒習慣於 Smoking/ Drinking habit since _____年/月/日(YY/MM/DD)</p>						
<p>本人謹此聲明曾為此病人作出診治, 而據本人所知所信, 以上填報的各項答案均屬正確。 I hereby certified that I did personally treat this patient and that the answers given above are all true to the best of my knowledge and belief.</p>							
<p>主診/專科醫生的姓名 (資歷) Name of Attending Physician/Specialist (with qualifications)</p> <p>主診/專科醫生簽名 (蓋印) Signature of Attending Physician/Specialist (with chop)</p>	<p>地址 Address</p> <p>日期 Date</p>						