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?	☐ 是 YES ☐ 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?	☐ 是 YES ☐ 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?	☐ 是 YES, 請提供詳情 Please provide details ☐ 否 NO 日期 Date / 醫生/醫院名稱 Name of Physician/Hospital / 診斷 Diagnosis / 治療詳情 Treatment Details
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?	☐ 是 YES, 請提供詳情 Please provide details ☐ 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.	日期 Date / 醫生/醫院名稱 Name of Physician/Hospital / 診斷 Diagnosis / 治療詳情 Treatment Details

11. 請提供此疾病的詳情: Please provide the details of this illness: (a) 腫瘤的確定位置 What is the site of the Tumor? (b) 腫瘤被界別為第幾級別? What is the staging of the Tumor? (c) 是否屬原位癌? Was it Carcinoma -in-situ? (d) 腫瘤是否完全在原位生長? Was the Tumor completely localized? (e) 惡性細胞是否不受控制地生長及蔓延? Was there uncontrolled growth of malignant cells? (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? (g) 腫瘤是否轉移到其他身體器官? Was there distant metastasis to other organ(s)? (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.)	(a) _____ (b) 級別 Staging_____級別分類 Staging System _____ (c) ☐ 是 YES ☐ 否 NO (d) ☐ 是 YES ☐ 否 NO (e) ☐ 是 YES ☐ 否 NO (f) ☐ 是 YES ☐ 否 NO (g) ☐ 是 YES ☐ 否 NO (h) ☐ 是 YES, 請提供詳情 Please provide details ☐ 否 NO 日期 Date 病理分析類別 Type of histological examination performed 結果 Result 若未有進行病理分析，原因為何? What is the reason if histological examination is not done?
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.)	檢驗日期 Test Date 檢驗項目 Test Item 結果 Result
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.	
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?	☐ 是 YES, 請提供活組織檢查報告及結果 Please provide the biopsy report and result ☐ 否 NO
15. 治療詳情 Treatment Details	☐ 電療 Radiotherapy ☐ 化療 Chemotherapy ☐ 舒緩治療 Palliative ☐ 手術 Surgical 手術名稱 Name of Surgery _____ ☐ 其他，請註明 Others, please specify _____
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?	☐ 否 NO ☐ 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 ☐ 心臟病 Cardiac problem ☐ 高血壓 Hypertension ☐ 高血脂 Hyperlipidaemia ☐ 糖尿病 Diabetes mellitus ☐ 乙型肝炎 Hepatitis B ☐ 人類免疫力缺乏病毒感染 HIV infection ☐ 曾接受手術 Previous operation ☐ 濫用藥物 Drug addiction ☐ 吸煙習慣 Smoking habit ☐ 飲酒習慣 Drinking habit ☐ 其他嚴重、慢性或先天性疾病 Other major, chronic or congenital illness _____ 詳情 Details: 診斷日期及醫生名稱 Diagnosis date and name of physician _____ 病歷之現況 Current condition of the above medical history ☐ 完全康復 Fully recovered ☐ 治療中 On Treatment _____ 吸煙/飲酒習慣於 Smoking/ Drinking habit since_____年/月/日(YY/MM/DD)

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.

主診/專科醫生的姓名 (資歷) Name of Attending Physician/Specialist (with qualifications)	地址 Address
主診/專科醫生簽名 (蓋印) Signature of Attending Physician/Specialist (with chop)	日期 Date