乙部 - 危疾(重疾) - 癌症 / 早期癌症 / 原位癌

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

(由主诊医生填写，所需费用由索偿人(理赔申請人)自行承担。 TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON AT THE CLAIMANT'S OWN EXPENSES)

病人姓名 Name of Patient	年龄及性别 Age & Sex	身份证号码 ID No.	职业 Occupation

1. 你是否病人惯常求诊的医生? Are you the patient's usual attending physician?	☐ 是 YES ☐ 否 NO 医疗纪录自 Medical records since_____(年/月/日) (YY/MM/DD)
2. 病人是否由其他医生转介? Was the patient referred by another physician?	☐ 是 YES ☐ 否 NO 转介医生的姓名和地址 Name and address of the referral physician _____
3. 病人因是次疾病的首次求诊日期 Date of first consultation for this illness	_____ (年/月/日) (YY/MM/DD)
4. 首次求诊的病征及病征出现日期 Symptoms presented and date of onset during the first consultation	病征 Symptoms _____ 病征出现日期 Symptoms Onset Date_____(年/月/日) (YY/MM/DD)
5. 诊断结果 Diagnosis of conditions	
6. 诊断日期 Date of diagnosis	_____ (年/月/日) (YY/MM/DD)
7. 患者確诊日期? When was the patient informed of the diagnosis?	日期 Date_____(年/月/日) (YY/MM/DD) 医生姓名 Name of physician_____
8. 病人曾否患有相关疾病? Has the patient previously suffered from related condition of this illness?	☐ 是 YES, 请提供详情 Please provide details ☐ 否 NO 日期 Date / 医生/医院名称 Name of Physician/Hospital / 诊断 Diagnosis / 治疗详情 Treatment Details
9. 既往是否有家族史或罹患本次疾病的不利因素? Is there any patient's family history or any precipitating factors which would have increased the risk of this illness?	☐ 是 YES, 请提供详情 Please provide details ☐ 否 NO
10. 请提供此疾病的所有求诊记录及治疗详情。 Please provide all the consultation history and details of this illness.	日期 Date / 医生/医院名称 Name of Physician/Hospital / 诊断 Diagnosis / 治疗详情 Treatment Details

11. 请提供此疾病的详情:
Please provide the details of this illness:

(a) 肿瘤的确定位置
What is the site of the Tumor?
(a) _____

(b) 肿瘤被界别为第几级别(肿瘤分期)?
What is the staging of the Tumor?
(b) 级别 Staging_____级别分类 Staging System _____

(c) 是否属原位癌?
Was it Carcinoma -in-situ?
(c) ☐ 是 YES ☐ 否 NO

(d) 肿瘤是否完全在原位生长?
Was the Tumor completely localized?
(d) ☐ 是 YES ☐ 否 NO

(e) 恶性细胞是否不受控制地生长及蔓延?
Was there uncontrolled growth of malignant cells?
(e) ☐ 是 YES ☐ 否 NO

(f) 肿瘤是否已浸润至其他邻近细胞或淋巴?
Was there any invasion of adjacent tissue or regional lymph node?
(f) ☐ 是 YES ☐ 否 NO

(g) 肿瘤是否转移到其他身体器官?
Was there distant metastasis to other organ(s)?
(g) ☐ 是 YES ☐ 否 NO

(h) 诊断是否经病理分析确定?
(请提供病理分析报告)
Is the diagnosis confirmed with histological examination?
(Please provide the histological report.)
(h) ☐ 是 YES, 请提供详情 Please provide details ☐ 否 NO

日期 Date	病理分析类别 Type of histological examination performed	结果 Result

若未有进行病理分析，原因为何? What is the reason if histological examination is not done?

12. 所有诊断检验的详情及结果。
(请提供所有诊断及化验报告)
Details of all diagnostic tests performed and the result.
(Please enclose copies of all diagnostic test and laboratory reports.)

检验日期 Test Date	检验项目 Test Item	结果 Result

13. 如诊断为白血病，请提供确实白血病之类别详情。
If the diagnosis is Leukaemia, please advise the type and details of Leukaemia.

14. 如诊断为皮肤癌，是否属恶性黑色素瘤?
If the diagnosis is Skin Cancer, was it malignant melanoma?
☐ 是 YES, 请提供活组织检查报告及结果 Please provide the biopsy report and result ☐ 否 NO

15. 治疗详情
Treatment Details
☐ 电疗 Radiotherapy ☐ 化疗 Chemotherapy ☐ 舒缓治疗 Palliative
☐ 手术 Surgical 手术名称 Name of Surgery _____
☐ 其他，请注明 Others, please specify _____

16. 病人过往有否右列之病历/ 习惯?
Has the patient ever had the medical illness(es) or the habit(s) as listed on the right column?
☐ 否 NO
☐ 是 YES, 请在适当位置划上剔号并提供详情 Please tick where it is appropriate and give details
- ☐ 心脏病 Cardiac problem
- ☐ 高血压 Hypertension
- ☐ 高血脂 Hyperlipidaemia
- ☐ 糖尿病 Diabetes mellitus
- ☐ 乙型肝炎 Hepatitis B
- ☐ 人类免疫力缺乏病毒感染 HIV infection
- ☐ 曾接受手术 Previous operation
- ☐ 滥用药物 Drug addiction
- ☐ 吸烟习惯 Smoking habit
- ☐ 饮酒习惯 Drinking habit
- ☐ 其他严重、慢性或先天性疾病 Other major, chronic or congenital illness _____

详情 Details:
诊断日期及医生名称 Diagnosis date and name of physician
_____
病历之现况 Current condition of the above medical history
☐ 完全康复 Fully recovered ☐ 治疗中 On Treatment _____
吸烟/饮酒习惯于 Smoking/ Drinking habit since_____年/月/日(YY/MM/DD)

本人谨此声明曾为此病人作出诊治，而据本人所知所信，以上填报的各项答案均属正确。
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.

主诊/专科医生的姓名 (资历) Name of Attending Physician/Specialist (with qualifications)	地址 Address
主诊/专科医生签名 (盖印) Signature of Attending Physician/Specialist (with chop)	日期 Date