

乙部 - 危疾 - 中风

PART II – CRITICAL ILLNESS – STROKE

(由主诊医生填写，所需费用由索偿人自行承担。 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?	<div><input type="checkbox"/> 是 YES<div>醫療紀錄自 Medical records since (年/月/日) (YY/MM/DD)</div></div> <div><input type="checkbox"/> 否 NO</div>		
2. 病人是否由其他医生转介? Was the patient referred by another physician?	<div><input type="checkbox"/> 是 YES<div>转介医生的姓名和地址 Name and address of the referral physician</div></div> <div><input type="checkbox"/> 否 NO</div>		
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. 首次求诊的病征及出现日期 Symptoms presented and date of onset during the first consultation	<div>病征 Symptoms</div> <div>病征出现日期 Symptoms Onset Date (年/月/日) (YY/MM/DD)</div>		
5. 诊断结果 Diagnosis of conditions			
6. 诊断日期 Date of diagnosis	(年/月/日) (YY/MM/DD)		
7. 病人何时被告知有关疾病的诊断? When and by whom was the patient informed of the diagnosis?	<div>日期 Date (年/月/日) (YY/MM/DD)</div> <div>医生姓名 Name of physician</div>		
8. 病人曾否患有相关疾病? Has the patient previously suffered from related condition of this illness?	<div><input type="checkbox"/> 是 YES, 请提供详情 Please provide details<div><div>日期 Date</div><div>医生/医院名称 Name of Physician/Hospital</div><div>诊断 Diagnosis</div><div>治疗详情 Treatment Details</div></div></div> <div><input type="checkbox"/> 否 NO</div>		
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机会? Is there any patient's family history or any precipitating factors which would have increased the risk of this illness?	<div><input type="checkbox"/> 是 YES, 请提供详情 Please provide details</div> <div><input type="checkbox"/> 否 NO</div>		
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.	<div><div>日期 Date</div><div>医生/医院名称 Name of Physician/Hospital</div><div>诊断 Diagnosis</div><div>治疗详情 Treatment Details</div></div>		

