乙部 - 危疾 – 中風

PART II – CRITICAL ILLNESS – STROKE

(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 and by whom 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. 中風事故之因由 Exact cause of the incident	☐ 腦組織梗塞 Infarction of brain tissue ☐ 腦出血 Cerebral haemorrhage ☐ 蛛網膜下腔出血 Subarachnoid haemorrhage ☐ 腦栓塞 Cerebral embolism ☐ 腦血栓 Cerebral thrombosis ☐ 其他，請註明 Others, please specify ______________
12. 腦部症狀是否因下列引致? Is the cerebral symptom due to the following? (a) 短暫性腦缺血 Transient Ischaemic Attacks	(a) ☐ 是 YES ☐ 否 NO
(b) 因意外事件或受傷、感染、血管炎及炎症性疾病引致的腦部受損 Brain damage due to an Accident or injury, infection, vasculitis, and inflammatory disease	(b) ☐ 是 YES ☐ 否 NO
(c) 引致視覺神經疾病或影響眼睛的血管疾病 Vascular disease affecting the eye or optic nerve	(c) ☐ 是 YES ☐ 否 NO
(d) 前庭系統缺血疾病 Ischaemic disorders of the vestibular system	(d) ☐ 是 YES ☐ 否 NO
(e) 其他顱外因素 Other extracranial source	(e) ☐ 是 YES ☐ 否 NO
13. 有否進行磁力共振掃描或電腦斷層掃描以確定此病? Has any imaging investigation or laboratory examination done e.g MRI or CT brain?	☐ 是 YES, 請提供詳情及檢驗報告 Please provide details and laboratory report ☐ 否 NO
14. 有否引起任何神經功能損害? Is there any neurological deficit(s) resulted?	☐ 是 YES, 請提供詳情 Please provide details ☐ 否 NO
(a) 神經功能損害的詳情及對病人的影響 Details of neurological deficit(s) and its impact on patient.	(a)
(b) 此神經功能損害由病發起持續了多久? How long has the neurological deficit(s) lasted from the date of onset?	(b)
(c) 此神經功能損害是否不可復原? Are the neurological deficit(s) irreversible?	(c) ☐ 是 YES ☐ 否 NO
(d) 此神經功能損害是否永久性? Are the neurological deficit(s) permanent?	(d) ☐ 是 YES ☐ 否 NO
(e) 是否經腦神經專科醫生確診? Is it confirmed by a neurologist?	(e) ☐ 是 YES ☐ 否 NO 腦神經專科醫生的姓名 Name of the neurologist ________________________________
15. 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
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