團體危疾賠償申請表-中風
GROUP CRITICAL ILLNESS CLAIM FORM - STROKE

中國人壽 CHINA LIFE | 海外

團體保單號碼 Group Policy No. | | | | | | | | | | |

第二部份 – 主診醫生報告書 (由主診醫生填寫，所有費用由僱員/病者/索償人自行承擔)
PART II – ATTENDING PHYSICIAN'S STATEMENT (To be completed by attending physician at the Employee's / Patient's / Claimant's own expenses.)

A. 病人資料 PARTICULARS OF PATIENT

1 病人姓名 Name of Patient

2 年齡及性別 Age and Sex

3 身份證/ 護照號碼 I.D. Card / Passport No.

B. 臨床資料 CLINICAL DETAILS

1 病人之醫療記錄可追溯至 We can trace the medical record of patient back to
年 Year 月 Month 日 Day

2 首次出現病徵日期發生日期 Date of the symptoms first appeared
年 Year 月 Month 日 Day

3 病人首次有關此病症之求診日期 Date of first consultation for this condition or related illness
年 Year 月 Month 日 Day

4 請詳細說明首次會診時之徵狀和病症 Please describe the symptoms and complaints at first consultation.

5 病人是否由其他醫生轉介？如是，請提供該醫生之姓名及地址。Is the patient referred by other physician? If yes, please give the name and address of the referring doctor. ☐ 是 Yes ☐ 否 No

6 診斷 Diagnosis

7 何時確診 When was the diagnosis made 年 Year 月 Month 日 Day

8 病人的病況是否由下列情況引致? Is patient's illness resulted by below conditions?
(1) 因短暫性腦缺血引致的腦部症狀 cerebral symptoms due to transient ischaemic attacks ☐ 是 Yes ☐ 否 No
(2) 任何可復原之缺血性神經機能缺損 any reversible ischaemic neurological deficit ☐ 是 Yes ☐ 否 No
(3) 因偏頭痛引致的腦部症狀 cerebral symptoms due to migraine ☐ 是 Yes ☐ 否 No
(4) 對眼或視神經或前庭系統功能造成影響的血管疾病 vascular disease affecting the eye or optic nerve or vestibular functions ☐ 是 Yes ☐ 否 No

9 是否有任何神經機能障礙? 如是，請提供詳細資料． Was there any neurological deficit? Is so, please provide details ☐ 是 Yes ☐ 否 No

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B. 臨床資料 (續) CLINICAL DETAILS (Continued)

10 該神經機能障礙是否屬永久性？如是，請提供該情況已持續多久． **Was there any permanent neurological deficit? Is so, please provide details for how long such deficit lasts for.** ☐ 是 Yes ☐ 否 No

11 請提供有關中風之治療、檢查及其結果、有否任何併發症及出院後之覆診或跟進計劃 **If so, please provide treatments, investigation procedures, results, and/or any complications and follow up plan regarding the stroke)**

C. 閣下之專業意見 PROFESSIONAL COMMENT

1 是次中風是否復發個案，或與過往其他病況有關？如是，請提供有關診治日期及治療詳情。**Is the stroke a recurrent episode or related to any previous conditions? If so, please provide details of the diagnosis and treatments.** ☐ 是 Yes ☐ 否 No

診治日期 **Date of diagnosis/treatments** 年 Year ____ 月 Month ____ 日 Day ____

詳情(包括診斷/治療/檢查及結果) **Details(including diagnosis/ treatments/ investigations and results)**

2 病人之家族史有否增加病人患上此症的風險? **Is there any patient's family history which would increase the risk of this illness?**

3 病情預測 **The prognosis of the condition**

4 是否與人體免疫缺損病毒有關 **Is it HIV related?**

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D. 其他醫療病史 OTHER MEDICAL HISTORY

1 病人過往有否以下病症/習慣。Does the patient have any medical history or habit as indicated below?

- ☐ 哮喘 Asthma
- ☐ 心臟病 Cardiac problem
- ☐ 糖尿病 Diabetes Mellitus
- ☐ 乙型肝炎 Hepatitis B
- ☐ 高血壓 Hypertension
- ☐ 曾接受手術 Previous operation
- ☐ 濫藥 Drug abuse
- ☐ 飲酒習慣 Drinking
- ☐ 吸煙習慣 Smoking
- ☐ 家族性癌症 Family history of cancer
- ☐ 家族病史 Unfavorable family history
- ☐ 以上皆沒有 None
- ☐ 其他疾病，請說明 Other disease, please specify _____

2 該病人曾否因患上述疾病或其他嚴重疾病接受醫生或醫院治療 ？ 如是者，請述詳情。Had the patient previously been treated or hospitalized for the above disease or other major disease? If so, please give details.

日期 Dates			疾病 Disease	治療/住院詳情 Details of treatment/hospitalization	醫生姓名/醫院名稱 Name of Physician/Hospital
年 Year	月 Month	日 Day			

3 請提供飲酒/吸煙習慣詳情 Please provide details of Drinking & Smoking habit.

習慣始自 Drinking/ Smoking start date since 年 Year ____ 月 Month ____ 日 Day ____

每日用量 Daily consumption _____ **(支/包/樽/罐 piece/ pack/ bottle/ can)**

E. 主診醫生資料及聲明 ATTENDING PHYSICIAN'S PARTICULARS AND DECLARATION

本人謹此聲明，就本人所知所信，上述由本人提供的資料均為事實之全部，並確實無訛。I HEREBY DECLARE that all the information provided by me in this form is true and correct to the best of my knowledge and belief.

主診醫生姓名 Name of Attending physician		**資歷 Qualification**			
地址 Address		**聯絡電話 Contact No.**			
主診醫生簽署及醫院/診所蓋章 Signature of Attending Physician and Stamp of Hospital / Clinic		**日期 Date**	年 Year	月 Month	日 Day