

危疾賠償申請表-原位癌及早期惡性腫瘤
CRITICAL ILLNESS CLAIM FORM – CARCINOMA-IN-SITU or EARLY MALIGNANCIES

 保單號碼 Policy No.

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第二部份 – 主診醫生報告書 (由主診醫生填寫, 所有費用由受保人/保單持有人/索償人自行承擔)
PART II – ATTENDING PHYSICIAN'S STATEMENT (To be completed by attending physician at the Insured / Policyholder / Claimant's own expenses.)

A. 病人資料 PARTICULARS OF PATIENT	
1 病人姓名 Name of Patient	<input style="width: 90%;" type="text"/>
2 年齡及性別 Age and Sex	<input style="width: 90%;" type="text"/>
3 身份證/ 護照號碼 I.D. Card / Passport No.	<input style="width: 90%;" type="text"/>
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.	
<input style="width: 90%; height: 30px;" type="text"/>	
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. <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	
<input style="width: 90%; height: 30px;" type="text"/>	
6 診斷 Diagnosis	
<input style="width: 90%; height: 30px;" type="text"/>	
7 何時確診 When was the diagnosis made	年 Year <input style="width: 20px;" type="text"/> 月 Month <input style="width: 20px;" type="text"/> 日 Day <input style="width: 20px;" type="text"/>
8 請提供病人是次診斷之原位癌所涉及的器官 Please provide the organs involved in the patient's diagnosis of carcinoma in situ:	
<input type="checkbox"/> 乳房 Breast	<input type="checkbox"/> 陰道或外陰 Vagina or vulva
<input type="checkbox"/> 子宮 Uterus	<input type="checkbox"/> 大腸及直腸 Colon and rectum
<input type="checkbox"/> 鼻咽 Nasopharynx	<input type="checkbox"/> 陰莖 Penis
<input type="checkbox"/> 睪丸 Testis	<input type="checkbox"/> 卵巢及/或輸卵管 Ovary and /or Fallopian tube
<input type="checkbox"/> 以上皆否 None of the above	<input type="checkbox"/> 其他, 請說明 Others, please specify <input style="width: 100px;" type="text"/>
9 上述第 8 題的原位癌被界別為第幾級別 (只限於子宮頸) What is the staging of Carcinoma-in-situ of the diagnosis made in Question 8? (For Cervix Uteri only)	
<input type="checkbox"/> CIN I <input type="checkbox"/> CIN II <input type="checkbox"/> CIN III <input type="checkbox"/> 其他 Others: <input style="width: 100px;" type="text"/>	
10 請提供前列腺癌之病理分期 Please provide the staging of malignant tumour of the prostate	
<input type="checkbox"/> T1a <input type="checkbox"/> T1b <input type="checkbox"/> T1c <input type="checkbox"/> PIN <input type="checkbox"/> 其他 Others: <input style="width: 100px;" type="text"/>	
11 請提供黑色素瘤皮膚癌之病理分期 Please provide the staging of malignant melanoma of skin	
<input type="checkbox"/> AJCC 第二期的黑色素瘤皮膚癌 Malignant melanoma of skin of AJCC stage II or;	
<input type="checkbox"/> AJCC 第二期或以上的非黑色素瘤皮膚癌 Melanoma skin cancer of AJCC stage II or;	
<input type="checkbox"/> 其他 Others: <input style="width: 100px;" type="text"/>	



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

- 12 腫瘤是否已浸潤至其他鄰近的細胞或器官組織? 如是, 請提供詳細資料。 Was there invasion of adjacent tissues? Is so, please provide details. 是 Yes 否 No

- 13 治療撮要(有關癌症之治療、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) Brief treatment summary (including treatments, investigation procedures, results, and/or any complications and follow up plan regarding the cancer)

C. 閣下之專業意見 PROFESSIONAL COMMENT

- 1 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?

- 2 病情預測 The prognosis of the condition

- 3 是否與人體免疫缺損病毒有關 Is it HIV related?

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?

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

- 2 該病人曾否因患上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