

保單號碼 Policy Number

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危疾賠償申請表 (冠狀動脈血管成形術)

CRITICAL ILLNESS CLAIM FORM (Coronary Angioplasty)

第二部份 (申請人自費由主診醫生填寫) PART II (To be completed by the Attending Physician at the Claimant's own expenses)			
病人姓名 Name of Patient			
身份證/護照號碼 ID Card / Passport No.		性別 Gender	

1. 臨床資料 Clinical details

(a) 病人之醫療紀錄自 Medical records of Patient since		(日 DD/月 MM/年 YYYY)
(b) 病人是否由其他醫生轉介? Was the patient referred by other physician? 如是, 請提供轉介醫生的姓名和聯絡資料 If yes, please give Name and Contact of the referring physician.	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No 醫生姓名 Name of doctor : 地址及電話 Address & Contact No. :	
(c) 病人因是次疾病的首次求診日期 Date of first consultation for this illness		(日 DD/月 MM/年 YYYY)
(d) 首次求診的病徵及病徵出現日期 Symptoms presented and Date of onset during the first consultation	病徵 Symptoms : 病徵出現日期 : Date of onset	(日 DD/月 MM/年 YYYY)
(e) 診斷結果 Diagnosis		
(f) 診斷日期 Date of diagnosis		(日 DD/月 MM/年 YYYY)

2. 醫療詳情及治療紀錄 Medical condition and Treatment records

(a) 手術日期及名稱 Date and Name of Surgery		(日 DD/月 MM/年 YYYY)
	<input type="checkbox"/> 球囊擴張成形術 Balloon Angioplasty <input type="checkbox"/> 動脈粥樣斑塊清除手術 Atherectomy <input type="checkbox"/> 激光治療法 Laser Treatment <input type="checkbox"/> 其他, 請說明 Other, please specify	
(b) 請提供此疾病的詳情: Please provide the details of this illness: (i) 有否心絞痛或胸痛病歷? Was there a history of angina or chest pain?	(i) <input type="checkbox"/> 是, 請提供詳情 Yes, please provide details : <input type="checkbox"/> 否 No	

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<p>(ii) 心電圖報告有否顯示 ST 段降低的變化？ Were there any ECG changes indicating ST segment depression?</p> <p>(iii) 請列出 *冠狀動脈狹窄的位置 Please list the location of *coronary arteries stenosis.</p> <p>(iv) 請詳述每條有關 *冠狀動脈狹窄之程度(%) Please specify the degree of stenosis (%) in respect of each involved artery.</p>	<p>(ii) <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No 測試日期 ECG Date (DD/MM/YYYY) : 心電圖結果 ECG Result :</p> <p>(iii) 位置 Location 1 : 位置 Location 2 :</p> <p>(iv) 位置 Location 1 : 位置 Location 2 :</p>						
<p>(c) 請提供此疾病的所有求診及檢驗詳情(請提供報告)。 Please provide all the consultation history and diagnostic test(s) of this illness (please enclose reports).</p>	<table border="1" style="width: 100%;"> <thead> <tr> <th style="width: 25%;">日期 Date (DD/MM/YYYY)</th> <th style="width: 25%;">醫生/醫院資料 Information of Doctor/Hospital</th> <th style="width: 50%;">檢驗項目及結果 Type(s) of Test & Result(s)</th> </tr> </thead> <tbody> <tr> <td style="height: 100px;"></td> <td></td> <td></td> </tr> </tbody> </table>	日期 Date (DD/MM/YYYY)	醫生/醫院資料 Information of Doctor/Hospital	檢驗項目及結果 Type(s) of Test & Result(s)			
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<p>(d) 請提供此疾病的所有治療詳情。 Please provide all the treatment details of this illness.</p>	<p>手術 / 療法 / 藥物名稱，請詳述： Name of Surgery / Therapy / Medication, please specify:</p>						
<p>(e) 病人現時的身體狀況及病情預測： Current & Prognosis of the patient's condition.</p> <p>病人會否出現任何併發症？ Has the patient ever had any complications?</p>	<p><input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No</p>						
<p>(f) 是次病況是否為復發性病或慢性病症？ Was the critical illness a recurrent episode or a chronic disease?</p>	<p><input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No</p> <p>如是，請提供首次病發日期： If yes, onset date of 1st episode (日 DD/月 MM/年 YYYY)</p>						

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3. 過往病歷 Past history

(a) 病人曾否在求診中透露其過往的醫療健康紀錄史？ Has the patient disclosed past medical health history during consultation(s)?	<input type="checkbox"/> 否 No <input type="checkbox"/> 是 Yes, 請填寫問題(b)至(d) Please fill in question (b) to (d)		
(b) 病人過去曾否患有同類病況？如有，請詳細說明。 Has the patient ever had the same or similar conditions or symptom before? If yes, please give a brief summary.	日期 Date (DD/MM/YYYY)	醫生/醫院資料 Information of Doctor/Hospital	疾病及治療 Disease & Details of Treatment
(c) 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?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No 請提供詳情 Please provide details :		
(d) 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?	<input type="checkbox"/> 否 NO <input type="checkbox"/> 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 <ul style="list-style-type: none"> <input type="checkbox"/> 高血壓 Hypertension <input type="checkbox"/> 高血脂 Hyperlipidaemia <input type="checkbox"/> 心臟病 Cardiac problem <input type="checkbox"/> 哮喘 Asthma <input type="checkbox"/> 糖尿病 Diabetes mellitus <input type="checkbox"/> 乙型肝炎 Hepatitis B <input type="checkbox"/> 人類免疫力缺乏病毒感染 HIV infection <input type="checkbox"/> 曾接受手術 Previous operation <input type="checkbox"/> 其他嚴重、慢性或先天性/遺傳疾病 Other major, chronic or congenital / heredity illness <hr/> 詳情 Details: 診斷日期及醫生名稱 Diagnosis date and name of physician <hr/> 病歷之現況 Current condition of the above medical history <input type="checkbox"/> 完全康復 Fully recovered <input type="checkbox"/> 治療中 On Treatment <hr/> 病人習慣 Patient's habit : <ul style="list-style-type: none"> <input type="checkbox"/> 濫用藥物 Drug addiction <input type="checkbox"/> 吸煙習慣 Smoking habit <input type="checkbox"/> 飲酒習慣 Drinking habit 上述習慣始於 The above habit since _____ (日 DD/月 MM/年 YYYY) 每日服用量 Daily consumption _____		

4. 主診醫生聲明書 Declaration of Attending Physician

主診醫生姓名 Name of Attending Physician	電話 Telephone No.
專業資格 Field of Specialization and Qualification	電郵 Email Address

本人謹此聲明本人曾親自為病人的病情和疾病進行了檢查、建議和治療，以上陳述是按本人專業所知所信真實及完整的填報。我在此聲明並同意將上述陳述作為索賠表的一部分。

I hereby declare that I have personally examined, advised and treated the Patient in connection to the conditions and illnesses herein and that the foregoing statements are true and complete to the best of my professional knowledge and belief. I hereby declare and agree to make my statements above as part of the claim form.

主診醫生簽署和蓋章
Signature and Official Chop of Attending Physician

簽署日期 Date of Signing
(日 DD/月 MM/年 YYYY)

簽署地 Place of Signing