中国太平 CHINA TAIPING

中國太平人壽保險(香港)有限公司
CHINA TAIPING LIFE INSURANCE(HONG KONG)COMPANY LIMITED

保單號碼 Policy Number

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危疾賠償申請表 (中風)
CRITICAL ILLNESS CLAIM FORM (Stroke)

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.	☐ 是 Yes ☐ 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)	中風事故之因由： Exact cause of the stroke event	☐ 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
(b)	腦部症狀是否因下列因素引致： Is the cerebral symptom due to the following source: (i) 短暫性腦缺血 Transient Ischaemic Attacks (ii) 椎基動脈供血不足 Attacks of vertebra-basilar Ischaemia (iii) 其他顱外因素 Other extracranial source	(i) ☐ 是 Yes ☐ 否 No (ii) ☐ 是 Yes ☐ 否 No (iii) ☐ 是 Yes ☐ 否 No

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(c)	請提供此疾病的所有求診及檢驗詳情(請提供報告包括磁力共振掃瞄或電腦斷層掃瞄檢查)。 Please provide all the consultation history and diagnostic test(s) of this illness (please enclose reports including MRI or CT brain).	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)
(d)	請提供此疾病的所有治療詳情。 Please provide all the treatment details of this illness.	手術 / 療法 / 藥物名稱，請詳述： Name of Surgery / Therapy / Medication, please specify:		
(e)	是次病況有否引起任何神經功能損害？ Is there any neurological deficit(s) resulted?	☐ 是 Yes ☐ 否 No 請提供詳情 Please provide details：		
	(i) 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.	(i)		
	(ii) 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?	(ii)		
	(iii) 此神經功能損害是否不可復原? Are the neurological deficit(s) irreversible?	(iii) ☐ 是 Yes ☐ 否 No		
	(iv) 此神經功能損害是否永久性? Are the neurological deficit(s) permanent?	(iv) ☐ 是 Yes ☐ 否 No		
	(v) 是否經腦神經專科醫生確診? Is it confirmed by a neurologist?	(v) ☐ 是 Yes ☐ 否 No 腦神經專科醫生姓名： Name of the neurologist		
(f)	病人現時的身體狀況及病情預測： Current & Prognosis of the patient's condition.			
	病人曾否出現任何併發症？ Has the patient ever had any complications?	☐ 是 Yes ☐ 否 No		
(g)	是次病況是否為復發性病症或慢性病症? Was the critical illness a recurrent episode or a chronic disease?	☐ 是 Yes ☐ 否 No 如是，請提供首次病發日期： If yes, onset date of 1st episode (日 DD/月 MM/年 YYYY)		

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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)?	☐ 否 No ☐ 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?	☐ 是 Yes ☐ 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?	☐ 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 ○ 高血壓 Hypertension ○ 高血脂 Hyperlipidaemia ○ 心臟病 Cardiac problem ○ 哮喘 Asthma ○ 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 ○ 其他嚴重、慢性或先天性/遺傳疾病 Other major, chronic or congenital / heredity 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 病人習慣 Patient's habit： ○ 濫用藥物 Drug addiction ○ 吸煙習慣 Smoking habit ○ 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