中國太平洋人壽保險(香港)有限公司
China Pacific Life Insurance (H.K.) Co. Ltd.

中国太平洋保险
China Pacific Insurance

危疾問卷 Critical Illness Questionnaire - 中風 Stroke

由註冊腦神經專科醫生填寫 (費用由索償人支付) To be completed by Registered Neurologist (at claimant's expenses)

病人姓名 Name of Patient	身份證 / 護照號碼 ID Card /Passport No.	年齡 Age	性別 Sex

1 a) 請提供以下診治日期 Please provide the following consultation dates :

病人的首次求診日期可追溯至
Patient's first consultation date can trace back to

______________________________(日 DD/月 MM/年 YY)

病人首次就中風相關症狀而向閣下求診之日期
First consultation date of the patient to you for Stroke related conditions

______________________________(日 DD/月 MM/年 YY)

b) 病人在首次求診上述病症時的體徵及病徵為何? What were the signs and symptoms of the patient at first consultation for the above illness?

c) 根據病人所述，有關的體徵及病徵於何時首次出現? According to the patient, when did the sign and symptoms first present?

______________________________(日 DD/月 MM/年 YY)

d) 根據閣下意見，您認為病人已患有此病症多久? In your opinion, how long has the patient suffered from this illness?

e) 請提供就此病曾進行的檢驗及附上所有檢驗報告的副本。Please provide details of tests / investigations done for this illness and enclose a copy of the reports to us.

日期 Date (日 DD/月 MM/年 YY)	檢驗 Tests / Investigations	結果 Result

f) 最後診斷名稱 Final Diagnosis:

____

診斷日期 Diagnosis Date:

______________________________ (日 DD/月 MM/年 YY)

g) 請提供診斷的全部細節及其臨床依據。 Please provide full details of the diagnosis and its clinical basis.

h) 病人是否由其他醫生/醫院轉介給閣下? Was the patient referred to you by other doctor/ hospital?

❏ 否 No ❏ 是，請提供詳情 :
Yes, please provide details:

i) 閣下曾否轉介病人予其他專科醫生? Did you refer the patient to any specialist for further management?

❏ 否 No ❏ 是，請提供詳情 :
Yes, please provide details:

j) 導致是次病症的潛在原因為何? What was the underlying cause for current cerebrovascular incident?

k) 病人的家族史是否有可能增加患上此病症的風險? Would the patient's family history increase the risk of suffering from this illness?

❏ 否 No ❏ 是，請提供詳情 :
Yes, please provide details:

2 a) 是次腦血管病發是否屬於以下情況? Was current cerebrovascular incident belonged to any of the following conditions?

i.	短暫性腦缺血發作 Transient Ischemia Attack	❏ 否 No	❏ 是 Yes
ii.	由於偏頭痛而導致的腦損傷 Brain damage due to migraine	❏ 否 No	❏ 是 Yes
iii.	對眼或視覺神經或前庭系統功能造成影響的血管疾病 Vascular disease affecting the eye, optic nerve or vestibular function	❏ 否 No	❏ 是 Yes

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b) 病人有否因是次腦血管病發而引致任何神經系統後遺症持續超過二十四(24)小時? 若有，請提供有關後遺症之詳情。 Did any neurological sequela of cerebrovascular incident last more than 24 hours? If yes, please provide details of neurological sequela?

❏ 否 No ❏ 是，請提供詳情 : Yes, please provide details:

c) 病人於病發後是否有神經功能受損持續超過至少四個星期? Has the neurological deficit been presented for at least four weeks from the date of the cerebrovascular incident?

❏ 否 No ❏ 是，請提供詳情 : Yes, please provide details:

3 a) 病人曾否因此病而入住醫院? Has the patient been hospitalized due to this illness?

❏ 否 No ❏ 是，請提供醫院的名稱及住院日期 : Yes, please provide hospital name & confinement period:

b) 請總括曾給予病人的治療(包括手術)、檢驗及結果。Summary of medical treatment given (including surgery) and tests performed with results.

c) 請提供現時和將來的治療計劃詳情，例如治療類型，方法，頻率和時段等。Please provide details of current and future planned treatment, e.g. type, method, frequency and duration of treatment, etc.

d) 病人的預後情況是甚麼? What is the prognosis of the patient?

4 據閣下所知，病人曾否有以下的習慣或狀況? 如有，請圈出並提供有關詳情。According to your knowledge, does the patient ever have any habit or medical conditions as listed below? If yes, please circle the appropriate and provide details.

吸煙 Smoking / 濫用藥物或酒精 Abuse of Drugs or Alcohol / 自招損傷 Self-inflicted Injury / 曾接受外科手術 Previous Operation / 後天免疫力缺乏症或人體免疫力缺乏病毒有關的疾病 AIDS or HIV Related Illness / 先天性疾病 Congenital Condition / 遺傳性疾病 Hereditary Condition / 長期病患 Chronic Disease / 長期傷殘 Long Term Disabilities / 以上皆非 None of the above.

詳情 Details：

5 其他備註 Other remarks:

簽署 (蓋章) Signature (with chop)

醫生姓名 (資格) Name of Doctor (with qualifications)

診所/醫院電話 Clinic / Hospital's Phone No.

日期 Date (日 DD/月 MM/年 YY)

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