

<p>Had the patient previously referred by other physician? 病人是否經其他醫生轉介?</p>	<p><input type="checkbox"/> Yes (please provide name & address of the doctor) 是 (請提供醫生姓名及地址) <input type="checkbox"/> No 否</p>															
<p>Details of the heart attack 有關心臟病發作詳情</p>	<p>Date of attack _____ / _____ / _____ (dd/mm/yyyy) 發作日期 (日/月/年)</p> <p>Duration of the acute symptom _____ 急性徵狀持續時期</p> <p>Was there a history of typical chest pain? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 是否有典型的胸痛病狀病歷?</p> <p>Were there any changes in ECG indicative of myocardial infarction? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 是否有新近的心電圖變化顯示急性心肌梗塞?</p> <p>Have any ECGs been performed prior to this infarct? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 於是次心肌梗塞前是否曾作心電圖檢查?</p> <p>If yes, please provide details (including date & result) and attach copies of both tracings. 若是, 請提供詳情 (包括日期及結果), 並附上有關的心電圖報告。</p> <p>_____</p> <p>_____</p> <p>Was the test of cardiac enzymes CK-MB or cardiac troponin T or I performed? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 是否有進行心肌酶 CK-MB 或肌鈣蛋白 T / I 的測試?</p> <p>If yes, please provide details (including date, type of test performed and result) and attach report copies. 若是, 請提供詳情 (包括測試日期、種類及結果), 並附上有關測試報告。</p> <p>_____</p> <p>_____</p> <p>Was there death of a portion of heart muscle? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 是否有部份的心肌壞死?</p>															
<p>Please provide details and results of all investigation performed. 請提供曾進行檢驗的詳情及結果。</p> <p><i>Please enclose copies of all the test reports. 請附上所有檢驗報告。</i></p>	<table border="1"> <thead> <tr> <th data-bbox="560 1128 804 1182">Date of Test 檢驗日期</th> <th data-bbox="804 1128 1305 1182">Test Item 檢驗項目</th> <th data-bbox="1305 1128 1517 1182">Result 結果</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Date of Test 檢驗日期	Test Item 檢驗項目	Result 結果	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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_____	_____	_____														
<p>Is there any patient's family history or other precipitating factors which would have increased the risk of this illness? 是次疾病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?</p>	<p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否</p>															
<p>Did the patient have any of the following habits - smoking, drinking or drugs taking? 病人是否有以下習慣 - 吸煙、飲酒或服用藥物?</p>	<p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否</p> <p><input type="checkbox"/> Smoking 吸煙 <input type="checkbox"/> Drinking 飲酒 <input type="checkbox"/> Drug taking 服用藥物</p> <p>Duration _____ Consumption per day _____ 持續時間 每天用量</p>															
<p>Do you know whether the patient was suffering from any other major, chronic or congenital disease? 你是否知道病人曾患有任何其他嚴重、慢性或先天疾病?</p>	<p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否</p>															

<p>Please list details of all medical conditions (apart from what have mentioned above) that the patient had ever consulted you with. 請提供病人過去曾向你求診的所有醫療病況詳情（除上述已提及外）。</p>	<p>Consultation date 求診日期</p>	<p>Complaints/Symptoms 主訴 / 病徵</p>	<p>Diagnosis 確診</p>	<p>Treatment given 所提供治療</p>
<p>Was there any usual physician of the patient other than you? 病人是否有其他慣常求診的醫生？</p>	<p><input type="checkbox"/> Yes (please provide name & address of the doctor) 是（請提供醫生姓名及地址） <input type="checkbox"/> No 否</p>			
<p>Any additional information you consider relevant to this claim. 其他與是次索償有關的資料。</p>				

Declaration 聲明

I hereby certify that I have personally examined and treated the patient in connection to the above condition and that the facts as given above present my opinion of his/her condition and all are true to the best of my knowledge and belief. I hereby declare that no information has been withheld by me at the request of the patient or his/her family.

本人謹此聲明曾親自為病人檢查及作出診治，以上填報的各項資料乃本人基於病人的情況而提供意見，所有答案，就本人所知所信，均為事實全部並確實無訛。本人在此聲明，沒有任何病人或其家屬要求本人隱瞞任何資料。

Name of Attending Physician / Specialist and Qualifications
主診 / 專科醫生姓名及資歷

Address and Contact No.
地址及聯絡電話號碼

Signature of Attending Physician / Specialist (with chop)
主診 / 專科醫生署名（蓋印）

Date (dd / mm / yyyy)
日期 (日 / 月 / 年)