The Medical Council of Hong Kong

Licensing Examination
Part II - Proficiency Test in Medical English

Sample Test Paper

Answer Book

QUESTION I

Circle *the word ' TRUE ' or ' FALSE '*

Note : One mark will be awarded for each question answered correctly, and one mark will be deducted for every wrong answer. No marks will be awarded or deducted if you leave the options blank.

1.	*True*	*False*
2.	*True*	*False*
3.	*True*	*False*
4.	*True*	*False*
5.	*True*	*False*
6.	*True*	*False*
7.	*True*	*False*
8.	*True*	*False*
9.	*True*	*False*
10.	*True*	*False*

Question No. _____ Seat No. _____

Question IV (b)

FORM 1

PREVENTION AND CONTROL OF DISEASE ORDINANCE

(Cap. 599)

TUBERCULOSIS NOTIFICATION

Particulars of Infected Person

Name in English:	Name in Chinese:	Age / Sex:	I.D. Card / Passport No.:
Residential Address:			Telephone No.: (Home) : (Mobile) : Patient : Family member : (Office / school / others):
Name and address of workplace / school / other institution:			
Job title / Class attended :			
Hospital / Clinic sent to (if any):			Hospital No.:

Site of TB (please ✓ all applicable)		Sputum (please ✓ and attach laboratory report if available)				Other specimens (specify and ✓ below):	
☐ Lung	☐ Meninges		Smear	Culture	PCR test	Smear	Culture
☐ Pleura	☐ Bone & Joint	Positive					
☐ Lymph node	☐ Urinary system	Negative					
☐ Miliary	☐ Genital system	Unknown					
☐ Other(s) (please specify):		Not done					

Duration of stay in Hong Kong: _____ Years

History of past treatment for TB
(delete whichever not applicable): Yes / No

If yes, YEAR first receiving treatment: _____

Disposal (please ✓ in front boxes and specify):

☐ Treatment started on: _____ (Date: dd/mm/yyyy)

☐ On observation

☐ Referred to _____ Hospital / Clinic / Private Practitioner

☐ Died on: _____ (Date: dd/mm/yyyy)

(Please DELETE whichever is not applicable)

I will arrange for examination of contacts myself. / Please arrange for examination of contacts.

Further Remarks:

Notified under the Prevention and Control of Disease Regulation by

Dr. _____ of _____Hospital / Clinic / Private Practice
(Full Name in BLOCK Letters)

_____ Ward / Unit / Specialty on _____ / _____ / _____ (Date: dd/mm/yyyy)

Telephone No.: _____ Fax No.: _____ _____
(Signature)

DH 1A(s)(Rev. Jul 2008)

FORM 2

PREVENTION AND CONTROL OF DISEASE ORDINANCE

(Cap. 599)

Notification of Infectious Diseases other than Tuberculosis

Particulars of Infected Person

Name in English:	Name in Chinese:	Age / Sex:	I.D. Card / Passport No.:
Residential address:			Telephone No. (Home): (Mobile): (Office / school / others):
Name and address of workplace / school:			
Job title / Class attended:			
Hospital / Clinic sent to (if any):			Hospital / A&E No.:

Disease ["✓"] below Suspected / Confirmed on _____ / _____ / _____ (Date: dd/mm/yyyy)

☐ Acute poliomyelitis	☐ *Haemophilus influenzae* type b infection (invasive)	☐ Rubella and congenital rubella syndrome
☐ Amoebic dysentery	☐ Hantavirus infection	☐ Scarlet fever
☐ Anthrax	☐ Invasive pneumococcal disease	☐ Severe Acute Respiratory Syndrome
☐ Bacillary dysentery	☐ Japanese encephalitis	☐ Shiga toxin-producing *Escherichia coli* infection
☐ Botulism	☐ Legionnaires' disease	☐ Smallpox
☐ Chickenpox	☐ Leprosy	☐ *Streptococcus suis* infection
☐ Chikungunya fever	☐ Leptospirosis	☐ Tetanus
☐ Cholera	☐ Listeriosis	☐ Typhoid fever
☐ Community-associated methicillin-resistant *Staphylococcus aureus* infection	☐ Malaria	☐ Typhus and other rickettsial diseases
☐ Creutzfeldt-Jakob disease	☐ Measles	☐ Viral haemorrhagic fever
☐ Dengue fever	☐ Meningococcal infection (invasive)	☐ Viral hepatitis
☐ Diphtheria	☐ Middle East Respiratory Syndrome	☐ West Nile Virus Infection
☐ Enterovirus 71 infection	☐ Mumps	☐ Whooping cough
☐ Food poisoning	☐ Novel influenza A infection	☐ Yellow fever
Number of persons known to be affected: ____	☐ Paratyphoid fever	
Place and district of consumption (e.g. "XX Restaurant in Mongkok"):	☐ Plague	
_____	☐ Psittacosis	
_____	☐ Q fever	
_____	☐ Rabies	
_____	☐ Relapsing fever	
Date of consumption: _____		

Notified under the Prevention and Control of Disease Regulation by

Dr. _____ of _____Hospital / Clinic / Private Practice
(Full Name in BLOCK Letters)

_____Ward / Unit / Specialty on _____ / _____ / _____ (Date: dd/mm/yyyy)

Telephone No.: _____ Fax No.: _____ _____
(Signature)

Remarks:

Restricted

REPORT TO DEPARTMENT OF HEALTH ON POISONING OR COMMUNICABLE DISEASES OTHER THAN THOSE SPECIFIED IN THE PREVENTION AND CONTROL OF DISEASE ORDINANCE

(CENTRAL NOTIFICATION OFFICE, CENTRE FOR HEALTH PROTECTION)

(FAX: 2477 2770; TEL: 2477 2772)

PARTICULARS OF AFFECTED PERSON

Name in English:	Name in Chinese:	Age/Sex:	I.D. Card/Passport No.:
Residential address:			Telephone Number: (Home): (Mobile): (Office/ school/ others):
Name and address of workplace/ school:			
Job title/ Class attended:			
Hospital/ Clinic sent to (if any) :			Hospital/A&E No.:

Disease ["✓"] below Suspected/Confirmed on _____/ _____ / _____.(dd/mm/yyyy)

☐ **Suspected Outbreak**

Please specify the nature of outbreak: _____

Number of persons affected: _____

☐ **Infectious Disease** that is rare, severe or important (e.g. acute flaccid paralysis, *Vibrio vulnificus* infection etc.)

Please specify: _____

☐ **Chinese medicine-related Adverse Event**

Please specify: _____

(Please attach supplementary form for reporting Chinese medicine-related adverse events)

☐ **Heavy Metal Poisoning**

Please specify: _____

☐ **Other Poisoning**

Please specify: _____

Remark: For occupational infection or poisoning specified in Schedule 2 of the Occupational Safety and Health Ordinance, please notify Labour Department as appropriate. Details can be found on the website http://www.labour.gov.hk

Reported by

Dr. _____ of _____ Hospital / Clinic / Private Practice
(Full Name in BLOCK Letters)

_____Ward / Unit / Specialty on _____/ _____/ _____(Date: dd/mm/yyyy)

Telephone No.: _____ Fax No.: _____ _____
(Signature)

Remarks:

Supplementary Form for Reporting
Chinese medicine-related Adverse Events

From: _____ Tel no.: _____

To: Central Notification Office, Centre for Health Protection, Department of Health

Fax: 2477 2770 (Tel: 2477 2772)

Part I Clinical history of patient

Presenting symptoms with date of onset:
Relevant medical history:
Relevant drug history:
Investigation(s) done and results (please provide a copy of relevant laboratory results):
Treatment given and current condition:
Follow up plan:

Part II Details of Incriminated Chinese Medicine (CM)

Name of CM in English:	Name of CM in Chinese:
Active ingredients of the CM (if known):	
Supposed indication for use:	Any people with same exposure: Y/N If yes, please provide name(s) and tel. nos.:
Dosage, preparation method and duration of consumption (please ***fax the prescription sheet*** and details of preparation together with this form if available):	
Any remnants or raw herbs collected from the patient? Y/N (Please note that **DH will analyse the contents of the remnants and raw herbs** if available.)	
Laboratory tests done on the herbs (if any) and results (please provide a copy of relevant laboratory results):	
Is the CM prescribed by a listed / registered CM practitioner? Y / N Name and address of CM practitioner whom the patient consulted:	
Name of herbal shop (if not dispensed by CM practitioner):	Address of herbal shop:

***** END OF ANSWER BOOK *****