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| **To be completed by the insurance company/applicant:** |
| **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Civil reg. no.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Claim no.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**For the physician (to be completed by the company):**

The answers to questions 17a and 17b should cover a period of [10] years prior to the date of the claim, which is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ddmm-yyyy

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| **To be completed by the examining physician** |
| **1** | a) Are you the patient´s general practitioner?b) If the answer to a) is no:Do you have another treatment-based association with the patient (speciality, place of treatment)?c) If the answer to a and b) is no:I have no treatment-based association with the patient and I have only seen the patient in connection with the completion of this certificate? | **NO YES** 🞎 🞎**NO YES** 🞎 🞎**NO YES** 🞎 🞎 | If **YES**, what kind?………………………………………………………………………………...………………………………………………………………………………... |
| **2** | Diagnosis in Danish and Latin |  | 1. Danish:1. Latin:2. Danish:2. Latin: |
| **3** | a) According to the patient, when did the first symptoms occur?b) Which symptoms? |  | Date: ………………………………….……………………………………..(day/mth/year) |
| **4** | a) According to the patient, when did he/she first consult a physician/request treatment in connection with the current accident?b) Whom did the patient consult the first time? |  | Date: ………………………………….……………………………………..(day/mth/year)🞎 General practitioner 🞎 Emergency room 🞎 Specialist🞎 Chiropractor 🞎 Physiotherapist 🞎 Other………………… |
| **5** | Does the patient state that he/she has been unconscious and/or suffered from short-term memory loss (amnesia) in connection with the injury? | **NO YES** 🞎 🞎 | If **YES**, please stateHow long? |
| **6** | Did the injury require hospital admission or outpatient treatment or rehabilitation at the hospital?  | **NO YES** 🞎 🞎 | If **YES**, please state Where?During which period? |
| **7** | a) Did the patient state that he/she is on sick leave?**If the answer to 7 a) is YES, please answer the below questions**b) Has a medical certificate of incapacity for work been issued? | **NO YES** 🞎 🞎🞎 🞎 | If **YES**, please state:During which periods?From date :………............. Duration:………………………….(day/mth/year) (number of days/weeks/mths) |
| **8** | Has imaging procedures been performed (such as x-ray examination, ultrasound scan, CT scan, MRI scan)? | **NO YES** 🞎 🞎 | If **YES**, please state:Which type of examination, where and when (copy of reading should be enclosed if possible)? What was the result? |
| **9** | a) What is the patient’s current condition? b) According to the patient, have there been periods without symptoms?c) In your assessment, from which date does it seem that there has been no significant progress or improvement in the condition?  | **NO YES** 🞎 🞎 | 🞎 Improved 🞎 Unchanged 🞎 WorseningIf **YES**, during which period? ……………………………………………………………………………………………………………………………….(mth/year) |
| **10** | a) Does the patient state that he/she has previously been treated for illnesses in the neck region? b) Does the patient state that he/she is undergoing treatment or rehabilitation?c) Does the patient state that he/she has been referred for further treatment or rehabilitation?d) Has treatment or rehabilitation been completed? | **NO YES** 🞎 🞎🞎 🞎🞎 🞎🞎 🞎 | If **YES**, please state: With whom and where (name and address)?When is it expected to be completed? ……………(day/mth/year)With whom and where (name and address)?When is it expected to start? ……………………(day/mth/year)When? …………………………(day/mth/year) |
| **11** | a) Does the patient state that he/she is able to attend work? b) Does the patient state that he/she is able to carry out the daily activities? (To be completed **only** for persons who do not work, such as pensioners or children)c) Does the patient state that he/she is able to oversee his/her business? (To be completed **only** for self-employed persons or persons in managerial positions)d) Which work functions up till now or daily activities does the patient find impossible to carry out? | **NO YES** 🞎 🞎🞎 🞎🞎 🞎 | If **YES**, please state:🞎 Part-time 🞎 Full-time🞎 Partly 🞎 Fully🞎 Part-time 🞎 Full-time |
| **12** | **To be completed only if the patient has stated in section 11 that there are activities which cannot be carried out.**What is the medical reason that the patient is not able to carry out these activities? |  |  |
| **13** | Are you able to assess at this time when the patient will be able to a) attend work? b) fully carry out the daily activities (to be completed **only** for persons who do not work, such as pensioners or children)? | **NO YES** 🞎 🞎🞎 🞎 | If **YES**, please state:🞎 Part-time 🞎 Full-timeApprox. from date :…………………………………………………………….(day/mth/year)🞎 Partly 🞎 FullyApprox. from date :…………………………………………………………….(day/mth/year) |
| **14** | What does the patient state about extent and nature of pain? |  |  |
| **15** | a) Does the patient complain of pain extending to the shoulder/arm?b) Does the patient complain of changes in the sense of touch? | **NO YES** 🞎 🞎🞎 🞎 | If **YES**, please state:Which?Where? |
| **16** | Is there clinical restricted cervical spine movement? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎 Light 🞎 Moderate 🞎 Severe |
| **17** | a) To your knowledge, has the patient had any illnesses, complaints or symptoms from the neck region within the last *[10]* years? b) Do you assess, on the existing basis, that illnesses or other conditions within the last *[10]* years have had any influence on the current injury or illness or exacerbated its consequences? | **NO YES** 🞎 🞎🞎 🞎 | If **YES**, please state:Which? Which? |
| **18** | Does the patient have other complaints or symptoms? | **NO YES** 🞎 🞎 | If **YES**, please state:Which? |
| **19** | a) In your assessment, will the injury or illness result in permanent disability?b) Assessment not possible at this time | **NO YES** 🞎 🞎🞎 🞎 | If **YES**, please state:Which?If **NO**, please state:Why not? |
| **20** | Date of examination |  | ………………………………………………………………………………..(day/mth/year) |

Any relevant discharge letters and examination results etc. may be enclosed

The medical information and assessments in this certificate are closely associated with the purpose of the certificate.

Unless otherwise stated, I accept that the company may provide the patient or his/her representative with a copy of the certificate.

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| This certificate has been completed by me in accordance with the existing medical records, my knowledge of the patient, my questions to the patient and my examination of the patient:………………….. ………………………………………………Date Physician’s signature**Exact address (stamp):** | The certificate is sent in a closed envelope marked "Attest" to:  |

Unless otherwise agreed prior to the request to the physician for completion of this certificate, the physician will receive payment upon submission of invoice in accordance with the physician’s terms of business. 04.04.36.04