|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 5a and 5b in the certificate should cover a period of *[10]* years prior to the date of the claim, which is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ddmm-yyyy | | | | | | |
| **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. Danish:  3. Latin: |
| **3** | | In your assessment, could continued or further treatment improve the patient’s condition? | | **NO YES**  🞎 🞎 | | If **YES**, which treatment or rehabilitation (brief description)?  If **NO**, in your assessment, from which date does it seem that there has been no significant progress or improvement in the patient’s condition?  ……………………………………………………………….  (day/mth/year) |
| **4** | | 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? |
| **5** | | a) To your knowledge, has the patient had any illnesses, complaints or symptoms in the same 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? |
| **6** | | a) Has the patient stated that he/she has resumed work or the daily activities?  **6 b) or 6 c) should only be completed if the answer to 6 a)**  **is No**  b) Are you able to assess at this time  when the patient will be able to attend work?  c) Are you able at this point to assess when the patient will be able to carry out the daily activities in full?  (To be completed **only** for persons who do not work, such as pensioners or children) | | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎 | | If **YES**, please state:  Approx. from date :…………………………………………………………….  (day/mth/year)  🞎 Part-time 🞎 Full-time  Approx. from date :…………………………………………………………….  (day/mth/year)  🞎 Partly 🞎 Fully  Approx. from date :…………………………………………………………….  (day/mth/year) |
| **7** | What are the patient’s complaints? | |  | |  | |
| **8** | Can the injury or illness be detected by a physical examination? | | **NO YES**  🞎 🞎 | |  | |
| **9** | Date of examination | |  | | Date: ………………………………….……………………………………..  (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. 04.05.41.04