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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 8a and 8b in the certificate 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 claimant’s usual ear, nose, and throat specialist?  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** | When did you first treat the claimant? |  | Date: ………..………….  (day/month/year) | | |
| **3** | According to the claimant, how did the acoustic trauma occur? |  |  | | |
| **4** | a) According to the claimant, which complaints/symptoms appeared in relation to hearing after the current injury/illness/acoustic trauma?  b) According to the claimant, when did the first symptoms appear? |  | Date: ………..………….  (day/month/year) | | |
| **5** | Which lesions and pathological conditions did you identify in the claimant which were caused by the current injury/illess/acoustic trauma? |  |  | | |
| **6** | Diagnosis in Danish and Latin: |  | 1. Danish:  1. Latin: | | |
| **7** | Any other relevant diagnoses should be stated in Danish and Latin: |  | 2. Danish:  2. Latin:  3. Danish:  3. Latin: | | |
| **8** | a) To your knowledge, has the patient had any illnesses, complaints or symptoms from the ears/hearing 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?  If **YES**, please state:  Which? | | |
| **9** | What complaints/symptoms does the claimant currently state? |  |  | |
| **10** | Does the claimant state that he/she is able to understand ordinary one-on-one conversation without background noise and without being able to see the face of the person speaking. | **NO YES**  🞎 🞎 |  | |
| **11** | Does the claimant state that he/she is able to understand ordinary one-on-one conversation without being able to see the face of the person speaking even if there is some background noise corresponding to a conversation in a car or in front of the television? | **NO YES**  🞎 🞎 |  | |
| **12** | Does the claimant state that he/she suffers from balance problems? | **NO YES**  🞎 🞎 | If **YES**, please state:  Which balance problems? | |

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| **13** | Has TONE AUDIOMETRY **been performed**?  **The following symbols should be used**  **Air conduction**   |  |  |  | | --- | --- | --- | | **○** | = | right ear | | ● | = | right ear masked | | × | = | left ear | |  | = | left ear masked |   **Bone conduction**   |  |  |  | | --- | --- | --- | | **[** | = | right ear | | **<** | = | right ear masked | | **]** | = | left ear | | **>** | = | left ear masked | | **bedste%20øres%20benledning** | = | bone conduction of best ear |   **Impedance**   |  |  |  | | --- | --- | --- | | **stapediusrefleks%20i%20højre%20øre** | = | acoustic reflex in right ear with sound in left ear | | **stapediusrefleks%20i%20venstre%20øre** | = | acoustic reflex in left ear with sound in right ear | | **stapediusrefleks%20i%20højre%20øre%20med%20lyd%20i%20venstre%20ikke%20udløst** | = | acoustic reflex in right ear with sound in left ear, not elicited | | **stapediusrefleks%20i%20venstre%20øre%20med%20lyd%20i%20højre%20ikke%20udløst** | = | acoustic reflex in left ear with sound in right ear, not elicited |   **Weber**   |  |  |  | | --- | --- | --- | | stapediusrefleks%20i%20venstre%20øre | = | Weber lateralized to right ear | | **stapediusrefleks%20i%20højre%20øre** | = | Weber lateralized to left ear | | **↕** | = | Weber in midline (no lateralization) | | **NO YES**  🞎 🞎 If **YES**, please complete the audiogram below:  (print-out from Auditbase may be enclosed)    Audiogram-funktionsattest    Date of recording of audiogram ........................  (day/month/year) | |
| **14** | Has **SPEECH AUDIOMETRY** been performed?   |  |  |  | | --- | --- | --- | | SRT | = | speech reception threshold | | DL | = | discrimination loss | | D | = | discrimination | | MCL | = | most comfortable level |   Discrimination loss (DL) in noise٭ (speech signal 65 dB SPL) in free field or headphone right + left?  Or discrimination (D) in noise٭ (speech signal 65 dB SPL) in free field or headphone right + left? | **NO YES**  🞎 🞎 | If **YES**, please state:   |  |  |  | | --- | --- | --- | |  | Right ear | Left ear | | SRT |  |  | | DL in quiet at MCL | % | % | | D in quiet at MCL | % | % | | MCL |  |  |   Date of recording of speech audiometry …………………………  (day/month/year)  ….…………%  ….…………%  ٭ For noise, the following should be stated:  Type of noise ...................................  Loudness of noise ................................... |

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| **15** | Did the otoscopy reveal any pathological findings? | **NO YES**  🞎 🞎 | If **YES**, please state:  Which findings? |
| **16** | Has the claimant stated that he/she suffers from tinnitus?   1. When did the claimant first notice the tinnitus? 2. Has the claimant stated that the tinnitus is constantly present? 3. Has the claimant stated that the tinnitus is intermittently present? | **NO YES**  🞎 🞎 | If **YES**, please state:  Date: ………..………….  (day/month/year)  🞎 In right ear 🞎 In left ear  🞎 In right ear 🞎 In left ear | |
| **17** | Does the claimant’s condition give rise to any further comments? |  |  | |
| **18** | Date of examination |  | ……………………………………………………………………………….  (day/month/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. 04.05.51.03