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| **To be completed by the insurance company/applicant:** | | | | | | | |
| **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Civil reg. no.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Claim number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **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:  What type of examination, where and when (A copy of the reading should be enclosed if possible)  What was the result? | |
| **5** | | 1. To your knowledge, has the patient had any illnesses, complaints or symptoms from hips or thighs within the last *[10]* years? 2. 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? | |
| **6** | | a) Does the patient state that he/she has resumed 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? to carry out? | | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎 | | 🞎Part-time 🞎 Full-time  🞎 Partly 🞎 Fully  🞎 Partly 🞎 Fully | |
| **7** | | **To be completed only if the patient has stated in section 6 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? |  | | |  | |
| **8** | | What are the patient’s current complaints? |  | | |  | |
| **9** | | b) Which side/region has been injured? |  | | | Right: Left:  🞎 Near the hip 🞎 Near the hip    🞎Mid-thigh 🞎Mid-thigh  🞎 Near the knee 🞎 Near the knee | |
| **10** | | a) Has the leg become shorter?  b) Has the leg position changed (for example outward rotation) | **NO YES**  🞎 🞎  🞎 🞎 | | | If **YES**, please state:    Cm: Cm:    How:    …………………….. ………………………  (for example degrees) (for example degrees) | |
| **11** | | a) Is there normal hip joint mobility?  b) Is there normal knee joint mobility?  c) Is there crepitus of the knee? | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎 | | | If **NO**, please complete the following:  Right Left  Stretching (ext.)  (normal 0/10) ˚) …………… …………..  Bending (flex.)  (norm 0-130˚) …………… …………..  Outward movement (abduction)  (norm 0-45˚) .…………… …………….  Inward movement (adduction)  (norm 0-30˚) ……………. …………….  Outward rotation  (norm 0-45˚) ……………… …………….    Inward rotation  (norm 0-40˚) ………………. ….…………  If **NO**, please complete the following:  Stretching/bending (flexion)  (norm 0-140˚) ……………. …………..  If **YES**, please state: Right: Left:  🞎 Light crepitus 🞎 Light crepitus  🞎 Moderate crepitus 🞎Moderate crepitus  🞎 Severe crepitus 🞎Severe crepitus | |
| **12** | d) Is there visible atrophy of the gluteal muscles?  b) Is there measurable atrophy of the thigh (10 cm above the patella)?  c) Is there measurable atrophy of the calf (largest circumference)? | | | | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎 | | If **YES**, please state: Right Left    🞎 Slightly 🞎Slightly    🞎 Moderately Moderately    🞎 🞎Severely Severely    Circumference (in cm) ……………….. ……………….    Circumference (in cm) ……………….. ………………. | |
| **13** | Is there free movement of ankle joint and toes? | | | | **NO YES**  🞎 🞎 | |  | |
| **14** | Are there oedema, varicose veins, scars? | | | | **NO YES**  🞎 🞎 | | If **YES**, please state:  Extent and location? | |
| **15** | Are there sensory disturbances? | | | | **NO YES**  🞎 🞎 | | If **YES**, please state:  Where: | |
| **16** | How is the gait (for example limping, uses a walking stick, two walking sticks, other aids)? | | | |  | |  | |
| **17** | Any comments? | | | |  | |  | |
| **18** | 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. 04.05.46.04