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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 5a and 5b 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 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** | | 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** | | a) To your knowledge, has the patient had any illnesses, complaints or symptoms from the forearm or wrist 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? |
| **6** | | c) 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? | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎 | | | If YES, please state:  🞎 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 complaints? |  | | |  | |
| **9** | | What is the site of the injury/illness? |  | | | 🞎 Near elbow 🞎 Middle of forearm 🞎 Near wrist | |
| **10** | | a) Is the patient right-handed/left-handed?  b) Which side has been injured? |  | | | 🞎 Right-handed 🞎 Left-handed  🞎 Right 🞎 Left | |
| **11** | | a) Is there malalignment at the site of the fracture? (To be completed **only** in case of fracture:)    b) Is there swelling?  c) Is there tenderness? | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎 | | | If **YES**, please state:  Right Left    🞎 🞎  🞎 🞎  🞎 🞎 | |
| **12** | | Is there normal shoulder joint mobility (with free shoulder blade)? | **NO YES**  🞎 🞎 | | | If **NO**, how is mobility:  Right Left  Forward-upwards (norm 0-180 - 180˚) …………….. . ……………..…  Outwards-upwards (norm 0-180˚) ……………….. ………………..  Backwards (norm 0-40 - 40˚) ……………... …………………  External rotation (norm 0-60˚) ……………… ………………..  (with horizontal forearm)  Internal rotation (norm 0-90˚) ……………… ………………..  (with horizontal forearm) | |
| **13** | | Is the elbow joint mobility, including rotation of forearm, normal? | **NO YES**  🞎 🞎 | | | If **NO**, how is mobility:  Right Left  Bending movement (ext./flex)  (norm 0 - 140˚) ……………. ……………….  External rotation (supination)  (norm 0 - 90˚) …………….. ……………….  Internal rotation (pronation)  (norm 0 - 90˚) ……………. ………………. | |
| **14** | Is there normal wrist mobility? | | | **NO YES**  🞎 🞎 | If **NO**, how is mobility reduced:  Right Left  Upwards (dorsal)  (norm 0-80˚) …………….. . ……………..…  Downwards (volar)  (norm 0-80˚) ……………… ………………..  Towards the thumb (radial)  (norm 0-30˚) ……………... …………………  Towards the little finger (ulnar)  (norm 0-40˚) ……………… ……………….. | | | |
| **15** | Is there crepitus of the wrists? | | | **NO YES**  🞎 🞎 | If **YES**, please state:  Right 🞎 Left 🞎 | | | |
| **16** | Are all fingers able to touch the palm? | | | **NO YES**  🞎 🞎 | If **NO**, please complete the following:  How many cm are they short of touching the palm of the hand (pulp-to-palm distance)?  Right Left  🞎 2nd digit …………..cm ………… cm  🞎 3rd digit ……..……..cm ………….cm  🞎 4th digit ……..……..cm ………….cm  🞎 5th digit ……..……..cm ………….cm | | | |
| **17** | Is there muscle atrophy:  a) of the upper arm (largest dimension)?  b) of the forearm (largest dimension)?  c) of the muscles of the hand? | | | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎 | If **YES**, please state:  Right Left  Circumference (in cm) ……………….. ……………….  Circumference (in cm) ……………….. ……………….  🞎 Light 🞎 Light  🞎 Moderate 🞎 Moderate  🞎 Severe 🞎 Severe | | | |
| **18** | Are there sensory disturbances? | | | **NO YES**  🞎 🞎 | If **YES**, please state:  In which region? | | | |
| **19** | In your assessment, is there reduced grip strength? | | | **NO YES**  🞎 🞎 | If **YES**, please state:  Right Left  🞎 Light 🞎 Light  🞎 Moderate 🞎 Moderate  🞎 Severe 🞎 Severe | | | |
| **20** | Are there circulatory or trophic disturbances? | | | **NO YES**  🞎 🞎 | If **YES**, please state:  Which? | | | |
| **21** | Any comments? | | |  |  | | | |
| **22** | 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. 04.05.44.04