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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 6a and 6b 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** | a) a) Has treatment (medical or other treatment) been terminated?  **If the answer to 4a) is YES, please answer question b):**  b) On which date was treatment (medical or other treatment) terminated? | | | | **NO YES**  🞎 🞎 | | Date:………………………………..……………………………………….  (day/mth/year)  Nature of most recent treatment:……………….…………………... |
| **5** | | 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? |
| **6** | | a) To your knowledge, has the patient had any illnesses, complaints or symptoms from the knees 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? |
| **7** | | 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? | | | | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎 | If **YES**, please state:  🞎Part-time 🞎 Full-time  🞎 Partly 🞎 Fully  🞎 Partly 🞎 Fully |
| **8** | | What is the medical reason that the patient is not able to carry out these activities?  **To be completed only if the patient has stated in section 7 that there are activities which cannot be carried out** | | | |  |  |
| **9** | | What are the patient’s current complaints? | | |  | |  |
| **10** | | | Which knee has been injured? | |  | | 🞎 Right 🞎 Left |
| **11** | | | a) According to the information received, is there or  has there been instances of knee locking?  **If the answer to 11 a) is YES, please answer the below questions.**  b) How often?  c) When was the last instance?  d) Do they cause interruption of work?  e) Have they resulted in bed rest?  f) Have they resulted in other treatment? | | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎  🞎 🞎 | | How long?  Which? |
| **12** | | | a) Has an arthroscopy of the knee been performed?  b) Has ligament reconstruction been performed in the knee?  c) Has the patient been referred for further examination?  d) Is the patient scheduled for surgery? | | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎  🞎 🞎 | | If **YES**, please state:  When? …………………………  (day/mth/year)  Place of treatment?  When? …………………………  (day/mth/year)  Place of treatment?  Date of referral .................................................................................  (day/mth/year)  Place of treatment?  When is surgery scheduled?..............................................................  (day/mth/year)  Place of treatment? |
| **13** | | | Is there crepitus of the knee? | **NO YES**  🞎 🞎 | | | If **YES**, please state: Right Left  🞎 Slightly 🞎 Slightly    🞎 Moderately 🞎 Moderately    🞎 Severely 🞎 Severely |
| **14** | | | Is there tenderness? | | **NO YES**  🞎 🞎 | | If **YES**, please state:  Where? |
| **15** | | | Is there normal knee joint mobility? | | **NO YES**  🞎 🞎 | | If **NO**, please complete the following:  Right Left  Stretching/bending (flexion)  (norm 0-140˚) ……………. ………….. |
| **16** | | | a) Is there abnormal mobility in the form of lateral instability?  b) Is there abnormal mobility in the form of anterior knee instability? | | **NO YES**  🞎 🞎  🞎 🞎 | | If **YES**, please state: Right Left  🞎Slightly 🞎 Slightly    🞎 Moderately 🞎 Moderately  🞎 Severely 🞎 Severely  🞎Slightly 🞎 Slightly    🞎 Moderately 🞎 Moderately  🞎 Severely 🞎 Severely |
| **17** | | | Has the position of the lower leg changed (for example knock-knee, bowleg)? | | **NO YES**  🞎 🞎 | | If **YES**, please state:  Which side and how? |
| **18** | | | Is there free mobility of the other joints in the leg? | | **NO YES**  🞎 🞎 | | If **NO**, please complete the following:  What is the reason? |
| **19** | | | Is there measurable muscle atrophy:  a) a) of the thigh (10 cm above the patella)?  b) b) of the calf (largest circumference)? | | **NO YES**  🞎 🞎  🞎 🞎 | | If **YES**, please state circumference in cm:    Right Left  Circumference (in cm) ............... ………...  Circumference (in cm) ……………….. ………………. ………... |
| **20** | | | If there soft tissue swelling of the knee joint?  a) Circumference of knee joint | | **NO YES**  🞎 🞎 | | If **YES**, please state:  Right Left  Circumference (in cm) ……………….. ………………. |
| **21** | | | a) Is there effusion in the right knee?  b) Is there effusion in the left knee? | | **NO YES**  🞎 🞎  🞎 🞎 | |  |
| **22** | | | Are there sensory disturbances? | | **NO YES**  🞎 🞎 | | If **YES**, please state:  Where? |
| **23** | | | Is the gait normal? | | **NO YES**  🞎 🞎 | | If **NO**, please complete the following:  Why not?  (for example limping, uses a walking stick, two walking sticks, other aids)? |
| **24** | | | Any comments? | |  | |  |
| **25** | | | 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. 04.05.47.04