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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 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. Danish:  3. Latin: | |
| **3** | a) Is there any clinical evidence on examination and palpation of the shoulder?  a) Is there any clinical evidence on examination and palpation of the elbow?  **To be completed only in case of fracture:**  a) Is there any clinical evidence on examination and palpation of the site of the fracture? | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎 | If **YES**, please state:  How?  How?  How? | |
| **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** | Has an arthroscopy been performed of the shoulder joint and/or elbow joint? | **NO YES**  🞎 🞎 | If **YES**, please state:  When? …………………………  (day/mth/year)  Place of treatment? | |
| **6** | a) To your knowledge, has the patient had any illnesses, complaints or symptoms from the shoulder, upper arm or elbow 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) Has the patient stated that he/she has resumed work or the daily activities?  **7 b) or 7 c) should only be completed if the answer to 7 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)  🞎 Part-time 🞎 Full-time  Approx. from date :…………………………………………………………….  (day/mth/year) | |
| **8** | What are the patient’s current complaints? |  |  | |
| **9** | Which region has been injured (possible fracture)? |  | 🞎 Shoulder 🞎 Upper arm 🞎 Elbow | |
| **10** | a) Is the patient right-handed/left-handed?  b) Which side has been injured? |  | 🞎 Right-handed 🞎 Left-handed  🞎 Right 🞎 Left | |
| **11** | Is there normal shoulder joint mobility (with free shoulder blade)? | **NO YES**  🞎 🞎 | If **NO**, how is mobility:  Right Left  Forward-upwards (norm 0 - 180˚) …………….. . ……………..…  Outwards-upwards (norm 0 - 180˚) ……………… …………………  Backwards (norm 0 - 40˚) ……………... …………………  External rotation (norm 0 - 60˚) ……………… ………………..  (with horizontal forearm)  Internal rotation (norm 0 - 90˚) ……………… ………………..  (with horizontal forearm) | |
| **12** | Is the elbow joint mobility, including rotation of forearm, normal? | **NO YES**  🞎 🞎 | If **NO**, how is mobility reduced?  Right Left  Bending movement (ext./flex)  (norm 0 - 140˚) …………….. ……………….  External rotation (supination)  (norm 0 - 90˚) …………….. ……………….  Internal rotation (pronation)  (norm 0 - 90˚) . ……………. ………………. | |
| **13** | Is there crepitus of the joint?  a) Shoulder joint  b) Shoulder/collarbone joint (acromioclavicular joint AC)  c) Elbow joint | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎 | | If **YES**, where is the crepitus?  Right Left  🞎 🞎  🞎 🞎  🞎 🞎 | |
| **14** | Do wrist and fingers move freely? | **NO YES**  🞎 🞎 | | If **NO**, please complete the following:  What are the restrictions? | |
| **15** | a) Is there visible atrophy of the shoulder rounding (deltoid muscle)?  b) Is there measurable atrophy of the upper arm (largest circumference)?  c) Is there measurable atrophy of the forearm (largest circumference)?  d) Is there visible atrophy of the muscles of the hand? | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎  🞎 🞎 | | If **YES**, please state:    Right Left  🞎 Light 🞎 Light  🞎 Moderate 🞎 Moderate  🞎 Severe 🞎 Severe    Circumference (in cm) ……………….. ……………….  Circumference (in cm) ……………….. ……………….  🞎 Light 🞎 Light  🞎 Moderate 🞎 Moderate  🞎 Severe 🞎 Severe | |
| **16** | Are there sensory disturbances? | **NO YES**  🞎 🞎 | | If **YES**, please state:  In which region? | |
| **17** | In your assessment, is there normal grip strength? | **NO YES**  🞎 🞎 | | If **NO**, please complete the following:  Right Left  🞎 Light 🞎 Light  🞎 Moderate 🞎 Moderate  🞎 Severe 🞎 Severe | |

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| **18** | 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) |
| **19** | Any comments? |  |  | |
| **20** | 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. 04.05.43.04