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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **To be completed by the examining physician** |
| **1** | a) Are you the claimant’s usual ophthalmologist?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** | a) According to the claimant, which complaints/symptoms appeared after the current injury/illness?b) According to the claimant, when did the first symptoms appear? |  |  Date: ………..………….(day/month/year) |
| **4** | Which lesions and pathological conditions did you identify in the claimant which were caused by the current injury/illess (see section 2)? |  |  |
| **5** | a) Diagnosis in Danish and Latin:b) Which eye is injured? |  | 1. Danish: 1. Latin: 🞎 Right 🞎 Left 🞎 Both |
| **6** | Does the claimant state that:a) he/she has been examined/treated by a practising specialist physician for the current injury/illness?b) he/she is currently being examined/treated by a practising specialist physician? | **NO YES** 🞎 🞎🞎 🞎 | If **YES**, please state:Which specialist physician?When will the examination/treatment be completed?....................................(day/month/year)Which specialist physician? |
| **7** | Does the claimant state that he/she has been hospitalized for the current injury/illness? | **NO YES** 🞎 🞎 | If **YES**, please state:Where? When? …………………………(day/month/year) |
| **8** | a) To your knowledge, has the patient had any illnesses, complaints or symptoms from the eyes 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** | If you have knowledge of the claimant’s visual acuity before the current injury/illness this should be stated (as a fraction for both eyes) If the claimant uses spectacles or contact lenses these must be worn during visual acuity measurements |  | Visual acuity (fraction) **before** the current injury/illness.Visual acuity of right eye ……..…………..Visual acuity of left eye ……..………….. |
| **11**  | Does the claimant state that he/she suffers from eye pain? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎Light pain 🞎 Moderate pain 🞎 Severe pain |
| **12** | Is the claimant blind (no vision) in one eye?**If YES, questions 13, 14, 15 and 16 should not be answered**  | **NO YES** 🞎 🞎 | If **YES**, please state:🞎 In right eye 🞎 In left eye  |
| **13** | Does the claimant state that he/she suffers from visual impairment? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎 In right eye 🞎 In left eye  |
| **14** | Does the claimant state that he/she suffers from double vision? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎 In right eye 🞎 In left eye  |
| **15** | Does the claimant state that he/she suffers from tearing? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎 In right eye 🞎 In left eye  |
| **16** | Does the claimant state that he/she suffers from glare? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎 In right eye 🞎 In left eye  |
| **17** | Does the claimant state that he/she suffers from eye irritation? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎 In right eye 🞎 In left eye  |
| **18** | Does the claimant state that he/she suffers from other symptoms? | **NO YES** 🞎 🞎 | If **YES**, please state:Which symptoms?  |

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| **19** | Are there changes in eye lids on physical examination?  | **NO YES** 🞎 🞎 | If **YES**, please state:🞎 At right eye 🞎 At left eye Which changes?  |
| **20** | Are there other changes to the eye surroundings (externally) than those stated in section 25? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎 At right eye 🞎 At left eye Which changes?  |
| **21** | Are there changes in the eyeball on physical examination? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎 Right eye 🞎 Left eye Which changes?  |
| **22** | What is the visual acuity (should be stated as a fraction for both eyes)? If the claimant uses spectacles or contact lenses these must be worn during visual acuity measurements |  | Visual acuity (fraction) **after** the current injury/illness.Visual acuity of right eye ……..…………..Visual acuity of left eye ……..………….. |
| **23** | Is the field of vision for fingers restricted in either eye?  | **NO YES** 🞎 🞎 | If **YES**, please state:Visual field in right eye…………….……………………………………..Visual field in left eye…………….…………………………………….. |
| **24** | Is there restricted eye movement causing double vision? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎 In right eye 🞎 In left eye  |
| **25** | Does the claimant’s condition give rise to any further comments?  |  |  |
| **26** | 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. 04.05.50.03