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

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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 | | |  | | Diagnosis in Danish:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diagnosis in 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) 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:  What type of examination, where and when  What was the result? | | | |
| **6** | a) To your knowledge, has the patient had any illnesses, complaints or symptoms from the fingers 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** | | 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? | | |  | | | 🞎 Part-time 🞎 Full-time  🞎 Partly 🞎 Fully  🞎 Partly 🞎 Fully | |
| **8** | | | **To be completed only if the patient has stated in section 7 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? | |  | | | |  |
| **9** | | | What are the patient’s current complaints? | |  | | | |  |
| **10** | | | a) Is the patient right-handed/left-handed?  b) Which hand has been injured? | |  | | | | 🞎 Right-handed 🞎 Left-handed  🞎 Right 🞎 Left |

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| **11** | Amputations, scars, sensory disturbances, fractures etc. may be shown in this drawing.  Amputations, scars and sensory disturbances may also be described in sections 12, 13 and 14, if necessary. |  | **Left**    **Dorsal Volar**  **Right**    **Dorsal Volar** |
| **12** | Amputations? | **NO YES**  🞎 🞎 | If **YES**, which fingers and which level? |
| **13** | Are there scars? | **NO YES**  🞎 🞎 | If **YES**, please state the location of the scar for each injured finger (dorsal - volar - radial - ulnar): |
| **14** | Are there sensory disturbances? | **NO YES**  🞎 🞎 | If **YES**, please state the location for each injured finger (dorsal - volar - radial - ulnar): |

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| **15** | Is there reduced finger mobility?  If **YES**, please fill in the table to the right.  Mobility must be stated for injured fingers **and** for contralateral fingers.  Regarding root joint of the thumb:  ”Thumb, root joint, up-down” means  measurement of the angle between the 1st and 2nd finger when the thumb is moved from the plane next to the 2nd finger to the plane in front of the 2nd finger.  ”Thumb, root joint, outward movement” means  measurement of the angle between the 1st and 2nd metacarpal bone when the thumb is moved in front of the 2nd finger. Measurement is made with the hand flat on the table.  **Note:** Empty fields for the individual fingers indicate normal movement. | **NO YES**  🞎 🞎 | Right Left  Thumb, root joint, up-down  (norm 0-70º) ………..……… …………..……  Thumb, root joint, outward movement  (norm 0-70º) ………..……… …………..……  Thumb, metacarpophalangeal joint  (norm 0-50º) ………..……… …………..……  Thumb, interphalangeal joint  (norm (0-80º) ………..……… …………..……  Distance to **base** of 2nd finger (cm ………..……… …………..……  Distance to **base** of 5th finger (cm ………..……… …………..……  **Other fingers:**  **2nd finger**  Metacarpophalangeal joint (norm 0-90º) ………..……… …………..……  Proximal interphalangeal joint (norm 0-100º) ………..……… …………..……  Distal interphalangeal joint (norm 0-90º) ………..……… …………..……  **3rd finger**  Metacarpophalangeal joint (norm 0-90º) ………..……… …………..……  Proximal interphalangeal joint (norm 0-100º) ………..……… …………..……  Distal interphalangeal joint (norm 0-90º) ………..……… …………..……  **4th finger**  Metacarpophalangeal joint (norm 0-90º) ………..……… …………..……  Proximal interphalangeal joint (norm 0-100º) ………..……… …………..……  Distal interphalangeal joint (norm 0-90º) ………..……… …………..……  **5th finger**  Metacarpophalangeal joint (norm 0-90º) ………..……… …………..……  Proximal interphalangeal joint (norm 0-100º) ………..……… …………..……  Distal interphalangeal joint (norm 0-90º) ………..……… …………..…… |

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| **16** | Is there impairment of the precision grip of the hand (precision grip between 1st and 2nd finger)? | **NO YES**  🞎 🞎 | If **YES**, please state: Right Left    🞎 Slightly 🞎 Slightly  🞎 Moderately 🞎 Moderately  🞎 Severely 🞎 Severely |
| **17** | 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 finger ……..……..cm ………….cm  🞎3rd finger ……..……..cm ………….cm  🞎4th finger ……..……..cm ………….cm  🞎5th finger ……..……..cm ………….cm |
| **18** | a) Is the pulp of the thumb able to touch the pulp of the other fingers?  b) Is the pulp of the thumb able to touch the base (distal bending lines) of the little finger? | **NO YES**  🞎 🞎  **NO YES**  🞎 🞎 | If **NO**, please complete the following:  How many cm is the pulp of the thumb short of touching the pulp of the other fingers?  Right Left  🞎 2nd digit …………..cm ………… cm  🞎 3rd digit ……..……..cm ………….cm  🞎 4th digit ……..……..cm ………….cm  🞎 5th digit ……..……..cm ………….cm  If **NO**, please complete the following:  How many cm is the pulp of the thumb short of touching the base of the little finger?  Right Left  🞎 5th digit ……..……..cm ………….cm |
| **19** | Is there impaired wrist mobility? | **NO YES**  🞎 🞎 | If **YES**, please state:  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˚) .……………….. ………………… |
| **20** | In your assessment, is the grip strength reduced? | **NO YES**  🞎 🞎 | If **YES**, please state: Right Left  🞎 Slightly 🞎 Slightly  🞎 Moderately 🞎 Moderately  🞎 Severely 🞎 Severely |
| **21** | Is there impairment of the elbow joint mobility, including rotation of forearm? | **NO YES**  🞎 🞎 | If **YES**, how is mobility impaired?  Right Left  Bending (ext./flex.)  (norm 0-140˚) ………………… ………………..  External rotation (supination)  (norm 0-90˚) ………………… ………………..  Internal rotation (pronation)  (norm 0-90˚) .……………….. ………………… |
| **22** | Is there normal shoulder joint mobility? | **NO YES**  🞎 🞎 |  |
| **23** | Is there muscle atrophy:  a) of the upper arm (largest dimension)?  b) of the forearm (largest dimension)? | **NO YES**  🞎 🞎 | Right Left  Circumference (in cm) ……………….. ……………….    Circumference (in cm) ……………….. ………………. |
| **24** | Are there circulatory or trophic disturbances? | **NO YES**  🞎 🞎 |  |
| **25** | Any comments? |  |  |
| **26** | 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. 04.05.45.04