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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 12a and 12b 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** | 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** | Diagnosis in Danish and Latin: |  | 1. Danish: 1. Latin:  |
| **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** | Does the claimant state that:a) he/she has been treated by a physiotherapist and/or chiropractor for the current injury/illness?b) he/she is currently being treated by a physiotherapist/chiropractor? | **NO YES** 🞎 🞎🞎 🞎 | If **YES**, please state:With whom?When will the examination/treatment be completed?....................................(day/month/year)With whom? |
| **9** | Does the claimant state that:1. he/she has been treated with

medication for the current injury/illness?b) he/she is currently being treated with medication as a result of the current injury/illness? | **NO YES** 🞎 🞎🞎 🞎 | If **YES**, please state:Which medication?If **YES**, please state:Which medication? |
| **10** | Does the claimant state that he/she has received other treatment than that stated in section 6, 7, 8 and 9?  |  | If **YES**, please state:How? Where? When? …………………………(day/month/year) |
| **11** | Does the claimant state that he/she has undergone an imaging procedure (such as x-ray examination, ultrasound scan, CT scan, MRI scan)?(A copy of the reading should be enclosed if possible) |  | If **YES**, please state:🞎 X-ray 🞎 Ultrasound 🞎 CT scan 🞎 MRI scanWhere?When? …………………………(day/month/year)Where? When? …………………………(day/month/year) |
| **12** | a) To your knowledge, has the patient had any illnesses, complaints or symptoms from the thoracic spine or lumbar spine 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? |
| **13** | a) Does the claimant state that he/she has been on sick leave due to the current injury/disease?**If the answer to a) is YES, please answer the below questions**b) Is there medical documentation for the notice of sick leave?c) Does the claimant state that he/she has resumed work? | **NO YES** 🞎 🞎🞎 🞎🞎 🞎 | If **YES**, please state:During which periods?From date :………............. To date :……….............(day/month/year) (day/month/year)If **YES**, from which date::….……………….(day/month/year)If **YES**, please state:According to the information provided, work has been resumed from date:…………………….(day/month/year) |
| **14** | Does the claimant state that he/she has changed to other work as a result of the current injury/illness?According to the claimant, from which date has he/she changed to other work? What type of work has the claimant changed to (job description)? | **NO YES** 🞎 🞎 | If **YES**, please state:Date: ………..…………. (day/month/year) |
| **15** | a) Is the claimant’s functional capacity affected by the current injury/illness?**If the answer to question a) is YES, please answer questions b), c) and d)** b) How do the medical sequelae of the injury/illness affect the claimant’s functional capacity?c) Do you consider the claimant’s functional capacity to be permanently impaired? d) Are there expectations of improvement, exacerbation or perhaps late complications which may affect the current injury/illness and thus the functional capacity? | **NO YES** 🞎 🞎🞎 🞎🞎 🞎 | If **YES**, please state:How? If **YES**, please state:How? |
| **16** | What complaints/symptoms does the claimant currently state? |  |   |
| **17**  | Does the claimant state that he/she suffers from back pain during rest? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎Light pain 🞎 Moderate pain 🞎 Severe pain |
| **18** | Does the claimant state that he/she suffers from back pain during physical strain? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎Light pain 🞎 Moderate pain 🞎 Severe pain |
| **19** | **To be completed only if the answer to questions 17 and/or 18 was YES**According to the claimant, how often does he/she suffer from back pain? |  | 🞎 Daily 🞎Often, but not daily |
| **20** | Does the claimant complain of sensory disturbances? | **NO YES** 🞎 🞎 | If **YES**, please state:Where? To what degree? 🞎 Light 🞎 Moderate 🞎 Severe  |
| **21** | Does the claimant complain of radiating pain? | **NO YES** 🞎 🞎 | If **YES**, please state:Where?  |
| **22** | Does the claimant complain of urinary discomfort as a result of the injury to the thoracic/lumbar spine? | **NO YES** 🞎 🞎 | If **YES**, please state:To what degree? 🞎 Light 🞎 Moderate 🞎 Severe 🞎 Incontinence |
| **23** | Is there clinically normal spinal mobility? | **NO YES** 🞎 🞎 | If **NO**, please complete the following:🞎 Reduced flexion 🞎 Reduced extension 🞎 Reduced side bending 🞎 Reduced rotation To what degree? 🞎 Light 🞎 Moderate 🞎 Severe  |
| **24** | What is the finger-floor distance (FFD) with straight knee joints?  |  | ……………. cm from finger tip to floor  |
| **25** | Does the claimant express tenderness on clinical palpation (feeling with hands and fingers) to the back? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎Light pain 🞎 Moderate pain 🞎 Severe pain |
| **26** | Are there effected reflexes? | **NO YES** 🞎 🞎 | If **YES**, please state:🞎 Patellar reflex To what degree? 🞎 Light 🞎 Moderate 🞎 Severe🞎 Achilles reflexTo what degree? 🞎 Light 🞎 Moderate 🞎 Severe |
| **27** | Is there paralysis above the foot joint (drop foot) with steppage gait?  | **NO YES** 🞎 🞎 | If **YES**, please state:🞎 Right 🞎 Partial paralysis 🞎 Total paralysis🞎 Left 🞎 Partial paralysis 🞎 Total paralysis |
| **28** | Are there sensory disturbances on physical examination? | **NO YES** 🞎 🞎 | If **YES**, please state:Where?  |
| **29** | Does the claimant’s condition give rise to any further comments?  |  |   |
| **30** | 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. 04.05.42.03