|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical certificate of incapacity to  work for the attention of the life  insurers’ consulting doctor** | | | | | | Policy no./Contract no./OASI no.:    Start of incapacity to work:  Disease  Accident | | | | | |
|  |  | | | | | | | | | | |
| **1. Patient** | |  |  | | --- | --- | | First name:  Date of birth:  Address: | Surname:  Sex: | | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **2. Occupation** | |  |  | | --- | --- | | Current occupation(s): | Workload:     hours/day     days/week  Employee  Self-employed  Currently not employed | | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **3. Treatment** | Outpatient treatment with you since:       until:  Previous outpatient treatment by (name, address, speciality and duration):   |  | | --- | |  |   Follow-up outpatient treatment by (name, address, speciality and duration):   |  | | --- | |  |   Inpatient treatment: where?   |  | | --- | |  |   From when to when?  In the case of surgery, please provide details:  When and where? | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **4. Medical history** | a) When and how did the disorder first appear? | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | b) Subjective patient details: | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | c) Had the patient been treated for this disorder previously?  Yes  No | | | | | | | | | | |
|  | |  | | --- | | If so, where? |   When? | | | | | | | | | | |
|  | d) Previous therapies: | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | e) Are there any pre-existing illnesses and/or consequences of accidents?  Yes  No | | | | | | | | | | |
|  | |  | | --- | | If so, please provide details: |   Since when?  Who was the consulting doctor/hospital?   |  | | --- | |  |   Are they affecting the healing process?  Yes  No   |  | | --- | | If so, to what extent? | | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **5. Objective**  **findings** | Examinations, findings of imaging tests, explanations and discharge reports (please provide copies): | | | | | | | | | | |
| |  | | --- | | Please provide details: |   Date: | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **6. Diagnosis** | ICD code and differential diagnosis, if applicable: | | | | | | | | | | |
| **with**  an impact on  capacity to work |  | | | | | | | | | | |
| **without**  an impact on  capacity to work |  | | | | | | | | | | |
|  | Objective restriction on current activities: | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **7. Other   factors** | Are there any factors that could have a negative impact on the healing process (e.g. working environment, social factors, commute to/from work, addiction)?  Yes  No | | | | | | | | | | |
|  | If so, please provide details: | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **8. Therapy** | a) Current treatment and medication (including dosage): | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | b) Procedure/suggestions (imaging diagnostics, examination by a specialist doctor, treatments, etc.): | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | c) Prognosis: | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **9. Incapacity**  **to work** | Manageable  workload:  (% of usual  workload): | | Manageable  presence  at work  (hours/day): | | Incapacity to work  as a %: | | | Incapacity to work  from: | | Incapacity to work  until: | |
|  |  |  | |  | | |  | |  | |
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|  |  | |  | |  | | |  | |  | |
|  | Return to work: planned from:       at     hours/day  expected in:     weeks at     hours/day | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **10. Reintegration** | a) Is another reasonable job/activity expected to be considered?  Yes  No | | | | | | | | | | |
|  | If so, which, and to what extent? | | | | | | | | | | |
|  | b) Has a new job/activity been started recently?  Yes  No | | | | | | | | | | |
|  | If so, please provide details: | | | | | | | | | | |
|  | c) Are there restrictions in the new job/activity?  Yes  No | | | | | | | | | | |
|  | If so, please provide details: | | | | | | | | | | |
|  | d) From a medical point of view, is there a restriction on driving a vehicle?  Yes  No | | | | | | | | | | |
|  | If so, please provide details: | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **11. Consultations** | Date of last consultation  Date of next consultation | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **12. Other**  **insurers** | Are other service providers involved (accident insurers,  sickness benefit insurers, invalidity insurance, military insurance, etc.)?  Yes  No | | | | | | | | | | |
| If so, please provide details: | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **13. Remarks** |  | | | | | | | | | | |

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| --- | --- | --- | --- | --- |
| Place and date: |  | Doctor’s address: |  | Doctor’s signature: |