

Short medical report

Daily sickness benefit

Claim number

Patient

First name Surname

Date of birth

Gender

Employer

Occupation

non-physical

physical

Cause

Illness

Accident

Pregnancy

Estimated date of birth

Diagnosis/diagnoses with impact on the patient's ability to work

ICD-10 diagnosis code

Are other specialists involved?

Yes

Name

Address

Specialisation

No

Has he insured person been or will they be hospitalised?

Operation

Inpatient

Partly inpatient

No

When and where

When is full ability to work planned?

Already planned for

0 – 2 months

2 – 4 months

4 – 6 months

>6 months

Notes

Place and date

Doctor's address

Doctor's signature

EAN

PAR

Phone

E-mail
