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DOCTOR'S QUESTIONNAIRE

This form can be filled out online and then printed.

www.pkrueck.com > Downloads > Kundenformulare > Doctor's questionnaire

GENERAL DETAILS

Name of pension institution ______________________________

First name / Name of insured person ______________________________

Date of birth of insured person ______________________________

Address of insured person ______________________________

Employer ______________________________

Excerpt from patient history commencing ____________________ (dd/mm/yyyy)

CAUSE OF UNFITNESS TO WORK

Diagnosis with ICD code ______________________________

Diagnosis with influence on incapacity for work ______________________________

Diagnosis without influence on incapacity for work ______________________________

When was the diagnosis made? ____________________ (dd/mm/yyyy)

In the case of an accident:

Date of accident ___________ (dd/mm/yyyy) Type of accident ______________________________

Was the accident caused by a third party? ☐ Yes ☐ No

OUTPATIENT TREATMENT

By you from ____________________ (dd/mm/yyyy) to ____________________ (dd/mm/yyyy)

Prior to you by Dr ______________ in ______________ since ______________ (dd/mm/yyyy)

Following you by Dr ______________ in ______________ since ______________ (dd/mm/yyyy)

How long have you known the patient? ____________________ (dd/mm/yyyy)

Is the insured person receiving regular treatment from you? ☐ Yes ☐ No

If yes, why? ______________________________

INPATIENT TREATMENT

Where? ______________________________

Date of admittance ______________ (dd/mm/yyyy) Date of discharge ______________ (dd/mm/yyyy)

ANAMNESIS AND PROGRESSION OF THE CASE

____

____

Type and duration of treatment ______________________________

Medication (including dosage) ______________________________ ☐ none

Possible earlier illnesses and accidents ______________________________

____

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DEGREE AND DURATION OF UNFITNESS TO WORK

Definition of "Unfitness to work": Unfitness to work is the full or partial inability to perform acceptable duties in the individual's previous occupation or area of activity caused by impairment of physical, mental or psychiatric health.
In the event of a longer duration acceptable employment in another occupation or area of activity will also be taken into consideration (Article 6 ATSG – Allgemeiner Teil des Sozialversicherungsrechts [General Section of the Swiss Federal Social Insurance Act1).

Degree and duration of unfitness to practice previous profession since occurrence of the first symptoms (independent of the employment market and economic situation in the case of 100% level of employment):

__________ % from ___________________ (dd/mm/vvvv) to ___________________ (dd/mm/vvvv)
__________ % from ___________________ (dd/mm/vvvv) to ___________________ (dd/mm/vvvv)
__________ % from ___________________ (dd/mm/vvvv) to ___________________ (dd/mm/vvvv)
__________ % from ___________________ (dd/mm/vvvv) to ___________________ (dd/mm/vvvv)

OTHER ACCEPTABLE OCCUPATION/WORK

Does any other kind of acceptable work come into question? ☐ Yes ☐ No
Is the insured person working in a new occupation? ☐ Yes ☐ No
If yes, which one? ____ since _________________ (dd/mm/vvvv)
Degree of disability in the new occupation _________ % from ___________ (dd/mm/vvvv) to _______ (dd/mm/vvvv)

DI / LAI / FMI

Has a report been made to the DI agency (early recognition)? ☐ Yes ☐ No If yes, when? __________ (dd/mm/vvvv)
If no, why not? ____
Has a notification been made? ☐ Yes ☐ No If yes, when? __________ (dd/mm/vvvv)
If yes, to whom? ☐ DI ☐ LAI ☐ FMI
Date of report / notification _____________________________ (dd/mm/vvvv)

RESUMPTION OF THE OCCUPATIONAL ACTIVITY

Can a resumption of the occupational activity or an increase in fitness to work be expected? ☐ Yes ☐ No
If yes, from ______________________ (dd/mm/yyyy) at _________ %
Would occupational measures or case management make sense? ☐ Yes ☐ No
If yes, in what form? (e.g. retraining, coaching,vocational consultation) ____
____
How do you estimate the prognosis? ____

Please send us copies of existing reports.

SPECIAL ISSUES, COMMENTS

____
____

Place, Date: ___________________________________ Stamp, Signature: _______________________________________

Doctor's fees:

Medical report CHF 45.-
Medical report with further details CHF 65.-

Please send the doctor's certificate and bank deposit slip to: **PKRück, Vertrauensärztlicher Dienst, Zollikerstrasse 4, Postfach, 8032 Zürich**