medical specialist's report of injury

Contract number

If the right to indemnity is recognized, costs up to € 10 to fill in this form will be covered by the insurance company.
Contact: AXA životní pojišťovna a.s., pobočka poisťovne z iného členského štátu, Kolárska 6, 812 55 Bratislava, Slovakia
AXA line: + 421 2 2929 2929, Fax: +421 2 5949 1112, E-mail: info@axa.sk, www.axa.sk

☐ **Daily compensation** ☐ **Permanent effects of injury**

Health insurance ☐ Yes ☐ No

Family name	Given name, title	Personal number

Address (Street number and name, Town/City)	Postcode	Phone

Identity document ☐ ID ☐ Pass	Number of identity document	Nationality

Injury details (to be completed by physician)

Are your findings consistent with patient's account of his/her personal injury? ☐ Yes ☐ No

Diagnosis – code

Name of physician and address of facility where first treatment was rendered

Date of first treatment

Hour of first treatment

Diagnosis – full description of all personal injuries caused by the accident

Has the injured organ already been functionally damaged before the accident, if available? ☐ Yes ☐ No

Date

Cause of injury

Description

Date of X-ray examination or other medical screening examinations

Description of X-ray examination or other medical screening examinations

Name of medical specialist who provides you with medical care

From

To

Course and method of treatment - **describe fully**

Did the accident happen under the influence of alcohol or other narcotics? ☐ Yes ☐ No

Type of narcotic

Blood alcohol content of ‰

Was the harm caused by intentionally self-inflicted injury? ☐ Yes ☐ No

Was treatment plan broken? ☐ Yes ☐ No

Has the injury resulted in any permanent effects? ☐ Yes ☐ No

If yes, please, describe them fully including the extent of the permanent effects

Is the extent of permanent effects already stable? ☐ Yes ☐ No

Hospitalized From To

Please, attach hospital release form and, in case of surgery, postoperative protocol as well.

Firm fixation From To

Rehabilitation From To

Work disability as a result of the injury inclusive From To

In case of children or students, please, specify duration of necessary medical treatment (non-school attendance) corresponding to work disability

Other physician's reports

If you need to use a separate sheet of paper, please, attach the signed paper with the contract number on it. Number of attached sheets

Declaration

I declare that information provided in the medical report refer to the person stated below.

Signatures

Signature date	Attending physician's address and phone number	Stamp and signature of attending physician

Place

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