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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Hals-, Nasen-, Ohren-Arztbericht** | | | | | | | | | | | | | | | | | | | | | | | | | **–** Auswahl **–** | | | | | | | | | | | | | | | | | | | | | | | Lfd. Nr. | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | […] | | | |
| Unfallversicherungsträger | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Eingetroffen am | | | | | | | | | | | | Uhrzeit | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | […] | | | | | | | | | | |
| Name der versicherten Person | | | | | | | | | | Vorname | | | | | | | | | | Geburtsdatum | | | | | | | | | Krankenkasse | | | | | | Familienversichert | | | | | | | | | | | Name des Mitglieds | | | | | |
| […] | | | | | | | | | | […] | | | | | | | | | | […] | | | | | | | | | […] | | | | | | Nein  Ja: keine Kopie an Kasse | | | | | | | | | | | […] | | | | | |
| Vollständige Anschrift | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Bei Pflegeunfall Pflegekasse der pflegebedürftigen Person | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | |
| Beschäftigt als | | | | | | | | | | | | | | | | Seit | | | | | | | | | | | | | Telefon-Nr. | | | | | | | | | | Staatsangehörigkeit | | | | | | | | | | Geschlecht | | |
| […] | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | […] | | | | | | | | | | […] | | | | | | | | | | […] | | |
| Unfallbetrieb (Name, Anschrift und Telefon-Nr. des Arbeitgebers, der Kita, der (Hoch-)Schule, der pflegebedürftigen Person) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 Unfalltag | | Uhrzeit | | | | | | | | | Unfallort | | | | | | | | | | | | | | | | | | Beginn der Arbeitszeit | | | | | | | | | | Ende der Arbeitszeit | | | | | | | | | | | | |
| […] | | […] | | | | | | | | | […] | | | | | | | | | | | | | | | | | | […] | | | | Uhr | | | | | | […] | | | | Uhr | | | | | | | | |
| 2 Angaben der versicherten Person zum Unfallhergang und zur Tätigkeit, bei der der Unfall eingetreten ist | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 Verhalten der versicherten Person nach dem Unfall | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4.1 Art der ersten (nicht HNO-ärztlichen) Versorgung | | | | | | | | | | | | | | | | | | | | | | 4.2 Erstmalig ärztlich behandelt am | | | | | | | | | | | | | | durch | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | | |
| 5 Befund (soweit im Zusammenhang mit dem Unfall von Bedeutung): | | | | | | | | | | | | | | | | | | | | | | | | | | | | 5.1 Beschwerden/Klagen | | | | | | | | | | | | | | | | | | | | | | |
| 5.2 Ohren: | Rechts: | | | | […] | | | | | | | | | | Links: | | | […] | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | |
| 5.3 Nase: | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.4 Mund und Rachen: | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.5 Kehlkopf und Luftröhre: | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.6 Hals und Gesicht: | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.7 Gehörfunktion: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Umgangssprache rechts | | | | | | | | | […] | | | | | m; links | | | | | […] | | | | m, Flüstersprache rechts | | | | | | | | | | | […] | | | | | | m; links | | | | | […] | | | | | m | |
| Weberversuch: | | | | […] | | | | | | | | | | | | | | | Rinneversuch rechts: | | | | | | | | […] | | | | | | | | | | links: | | | | | […] | | | | | | | | |
| Tonaudiogramm: | | | | […] | | | | | | | | | | | | | | | Ohrgeräusche | | | | | Nein | | | | | | Ja, ggf. welche? | | | | | | | | Rechts: | | | | | | | | | […] | | | |
|  | | | |  | | | | | | | | | | | | | | |  | | | | |  | | | | | | Vorbestehend? (bitte unter Pkt. 9 angeben) | | | | | | | | Links: | | | | | | | | | […] | | | |
| 5.8 Gleichgewichtsfunktion: | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Spontannystagmus: | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provokationsnystagmus (Kopfschütteln, Lage, Lagerung usw.): | | | | | | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Experimentelle Prüfung: (Spülung warm - kalt, Drehung usw.): | | | | | | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Abweichreaktionen (Romberg, Unterberger usw.): | | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.9 Riech- und Geschmacksprüfung: | | | | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.10 Sonstige Befunde: | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6 Ergebnis bildgebender Diagnostik | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7 Erstdiagnose **- Freitext -** (Änderungen/Konkretisierungen **unverzüglich** nachmelden) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **ICD 10** | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | […] | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| 8 Art der HNO-ärztlichen Versorgung | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 Vom Unfall unabhängige gesundheitliche Beeinträchtigungen, die für die Beurteilung des Arbeitsunfalls von Bedeutung sein können | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 Ergeben sich aus Hergang und Befund Zweifel an einem Arbeitsunfall? Wenn ja, ist eine Kopie des HNO-Arztberichts auszuhändigen. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nein  Ja, weil | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11 **Art der Heilbehandlung** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allgemeine Heilbehandlung  Besondere Heilbehandlung, weil eingeleitet von D-Ärztin/D-Arzt (Bitte genaue Anschrift angeben.) | | | | | | | | | | | | | | | | | | | | | | | | | | Ambulant  Stationär | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12 **Weiterbehandlung erfolgt**  durch mich  durch andere Ärztin/anderen Arzt (auch Verlegung/Vorstellung), bitte Name und Anschrift angeben | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13 **Beurteilung der Arbeitsfähigkeit**  Arbeitsfähig  Arbeitsunfähig ab […] | | | | | | | | | | | | Voraussichtlich wieder arbeitsfähig ab […]  Voraussichtlich länger als 3 Monate arbeitsunfähig | | | | | | | | | | | | | | | | | | | 14 **Ist die Zuziehung weiterer Ärztinnen/Ärzte zur Klärung der Diagnose und/oder Mitbehandlung erforderlich?**  Nein  Ja, zugezogen wird […] | | | | | | | | | | | | | | | | | | | |
| 15 Bemerkungen (z. B. Beratungsbedarf durch Reha-Management des UV-Trägers, Kontextfaktoren, besondere Umstände) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Datum | | | Name und Anschrift (Stempel) der HNO-Ärztin/des HNO-Arztes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Unterschrift der HNO-Ärztin/des HNO-Arztes | | | | | | | | | | | | | | | | | | | |
| […] | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | |

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| --- | --- | --- | --- |
| Name, Vorname: | Geburtsdatum: | Unfalltag: | Lfd. Nr. |
| […], […] | […] | […] | […] |

Weitere Ausführungen

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| […] | | | | | | | | | |
| **Datenschutz:** Ich habe die Hinweise nach § 201 SGB VII gegeben. | | | | | | | | | |
| **Rechnung Nur abrechnen, wenn keine Weiterbehandlung durch Sie vorgesehen ist. Ansonsten Abrechnung bitte zusammen mit Ihrer Behandlungsrechnung.** | | | | | | | | | |
| Berichtsgebühr nach Nr. | | 127 | UV-GOÄ |  | […] EUR |  | **Besondere Kosten** | | |
| Ärztliche Leistung nach Nr. | | […] | UV-GOÄ |  | […] EUR |  | | […] EUR |  |
| nach Nr. | | […] | UV-GOÄ |  | […] EUR |  | | […] EUR |  |
| nach Nr. | | […] | UV-GOÄ |  | […] EUR |  | | […] EUR |  |
| nach Nr. | | […] | UV-GOÄ |  | […] EUR |  | | […] EUR |  |
| Summe Besondere Kosten | | | |  | […] EUR |  | |  |  |
| Porto |  | | |  | […] EUR |  | | | |
|  |  | | |  |  |  | | | |
|  | zusammen | | |  | […] EUR |  | | | |
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|  |  |
| --- | --- |
| Rechnungsnummer  […] | **Institutionskennzeichen (IK)**  […]  **Falls kein IK** - Bankverbindung (IBAN) - |

**Verteiler**

Unfallversicherungsträger

Behandelnde Ärztin/Behandelnder Arzt

Eigenbedarf

Krankenkasse (Kurzbericht), nicht bei familienversicherten Personen

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Hals-, Nasen-, Ohren-Arztbericht** | | | | | | | | | | | | | | | | | | | | | | | | **– Für den behandelnden Arzt/ die behandelnde Ärztin –** | | | | | | | | | | | | | | | | | | | | | | | Lfd. Nr. […] | | | |
| Unfallversicherungsträger | | | | | | | | | | | | | | | | | | | | | | | | | | | | Eingetroffen am | | | | | | | | | | | | Uhrzeit | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | […][…] | | | | | | | | | | |
| Name der versicherten Person | | | | | | | | | | Vorname | | | | | | | | | Geburtsdatum | | | | | | | | | Krankenkasse | | | | | | Familienversichert | | | | | | | | | | | Name des Mitglieds | | | | | |
| […] | | | | | | | | | | […] | | | | | | | | | […] | | | | | | | | | […] | | | | | | Nein  Ja: keine Kopie an Kasse | | | | | | | | | | | […] | | | | | |
| Vollständige Anschrift | | | | | | | | | | | | | | | | | | | | | | | | | | | | Bei Pflegeunfall Pflegekasse der pflegebedürftigen Person | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | |
| Beschäftigt als | | | | | | | | | | | | | | | Seit | | | | | | | | | | | | | Telefon-Nr. | | | | | | | | | | Staatsangehörigkeit | | | | | | | | | | Geschlecht | | |
| […] | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | […] | | | | | | | | | | […] | | | | | | | | | | […] | | |
| Unfallbetrieb (Name, Anschrift und Telefon-Nr. des Arbeitgebers, der Kita, der (Hoch-)Schule, der pflegebedürftigen Person) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 Unfalltag | | Uhrzeit | | | | | | | | Unfallort | | | | | | | | | | | | | | | | | | Beginn der Arbeitszeit | | | | | | | | | | Ende der Arbeitszeit | | | | | | | | | | | | |
| […] | | […] | | | | | | | | […] | | | | | | | | | | | | | | | | | | […] | | | | Uhr | | | | | | […] | | | | Uhr | | | | | | | | |
| 2 Angaben der versicherten Person zum Unfallhergang und zur Tätigkeit, bei der der Unfall eingetreten ist | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 Verhalten der versicherten Person nach dem Unfall | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4.1 Art der ersten (nicht HNO-ärztlichen) Versorgung | | | | | | | | | | | | | | | | | | | | | 4.2 Erstmalig ärztlich behandelt am | | | | | | | | | | | | | | durch | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | | |
| 5 Befund (soweit im Zusammenhang mit dem Unfall von Bedeutung): | | | | | | | | | | | | | | | | | | | | | | | | | | | 5.1 Beschwerden/Klagen | | | | | | | | | | | | | | | | | | | | | | |
| 5.2 Ohren: | Rechts: | | | | […] | | | | | | | | | Links: | | | […] | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | |
| 5.3 Nase: | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.4 Mund und Rachen: | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.5 Kehlkopf und Luftröhre: | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.6 Hals und Gesicht: | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.7 Gehörfunktion: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Umgangssprache rechts | | | | | | | | | […] | | | | m; links | | | | | […] | | | | m, Flüstersprache rechts | | | | | | | | | | | […] | | | | | | m; links | | | | | […] | | | | | m | |
| Weberversuch: | | | | […] | | | | | | | | | | | | | | Rinneversuch rechts: | | | | | | | | […] | | | | | | | | | | links: | | | | | […] | | | | | | | | |
| Tonaudiogramm: | | | | […] | | | | | | | | | | | | | | Ohrgeräusche | | | | | Nein | | | | | | Ja, ggf. welche? | | | | | | | | […] Rechts: | | | | | | | | | […] | | | |
|  | | | |  | | | | | | | | | | | | | |  | | | | |  | | | | | | Vorbestehend? (bitte unter Pkt. 9 angeben) | | | | | | | | Links: | | | | | | | | | […] | | | |
| 5.8 Gleichgewichtsfunktion: | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Spontannystagmus: | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provokationsnystagmus (Kopfschütteln, Lage, Lagerung usw.): | | | | | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Experimentelle Prüfung: (Spülung warm - kalt, Drehung usw.): | | | | | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Abweichreaktionen (Romberg, Unterberger usw.): | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.9 Riech- und Geschmacksprüfung: | | | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.10 Sonstige Befunde: | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 6 Ergebnis bildgebender Diagnostik | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7 Erstdiagnose **- Freitext -** (Änderungen/Konkretisierungen **unverzüglich** nachmelden) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **ICD 10** | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | […] | | | | | | |
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| 8 Art der HNO-ärztlichen Versorgung | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 Vom Unfall unabhängige gesundheitliche Beeinträchtigungen, die für die Beurteilung des Arbeitsunfalls von Bedeutung sein können | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 Ergeben sich aus Hergang und Befund Zweifel an einem Arbeitsunfall? Wenn ja, ist eine Kopie des HNO-Arztberichts auszuhändigen. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nein  Ja, weil | | | | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 11 **Art der Heilbehandlung** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allgemeine Heilbehandlung  Besondere Heilbehandlung, weil eingeleitet von D-Ärztin/D-Arzt (Bitte genaue Anschrift angeben.) | | | | | | | | | | | | | | | | | | | | | | | | | Ambulant  Stationär | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12 **Weiterbehandlung erfolgt**  durch mich  durch andere Ärztin/anderen Arzt (auch Verlegung/Vorstellung), bitte Name und Anschrift angeben | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13 **Beurteilung der Arbeitsfähigkeit**  Arbeitsfähig  Arbeitsunfähig ab […] | | | | | | | | | | | Voraussichtlich wieder arbeitsfähig ab […]  Voraussichtlich länger als 3 Monate arbeitsunfähig | | | | | | | | | | | | | | | | | | | 14 **Ist die Zuziehung weiterer Ärztinnen/Ärzte zur Klärung der Diagnose und/oder Mitbehandlung erforderlich?**  Nein  Ja, zugezogen wird […] | | | | | | | | | | | | | | | | | | | |
| 15 Bemerkungen (z. B. Beratungsbedarf durch Reha-Management des UV-Trägers, Kontextfaktoren, besondere Umstände) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Datum | | | Name und Anschrift (Stempel) der HNO-Ärztin/des HNO-Arztes | | | | | | | | | | | | | | | | | | | | | | | | | | | | Unterschrift der HNO-Ärztin/des HNO-Arztes | | | | | | | | | | | | | | | | | | | |
| […] | | | […] | | | | | | | | | | | | | | | | | | | | | | | | | | | | […] | | | | | | | | | | | | | | | | | | | |

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| Name, Vorname: | Geburtsdatum: | Unfalltag: | Lfd. Nr. |
| […], […] | […] | […] | […] |

Weitere Ausführungen

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| […] |
| **Datenschutz:** Ich habe die Hinweise nach § 201 SGB VII gegeben. |

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| **Hals-, Nasen-, Ohren-Arztbericht** | | | | | | | | **– Für die Krankenkasse –** | | | | | | | | | | | | Lfd. Nr.  […] | | |
| Unfallversicherungsträger | | | | | | | | | | Eingetroffen am | | | | | | Uhrzeit | | | | | | |
| […] | | | | | | | | | | […] | | | | | | […][…] | | | | | | |
| Name der versicherten Person | | | | Vorname | | | Geburtsdatum | | | Krankenkasse | | | | Familienversichert | | | | | Name des Mitglieds | | | |
| […] | | | | […] | | | […] | | | […] | | | | Nein  Ja: keine Kopie an Kasse | | | | | […] | | | |
| Vollständige Anschrift | | | | | | | | | | Bei Pflegeunfall Pflegekasse der pflegebedürftigen Person | | | | | | | | | | | | |
| […] | | | | | | | | | | […] | | | | | | | | | | | | |
| Beschäftigt als | | | | | | Seit | | | | Telefon-Nr. | | | | | Staatsangehörigkeit | | | | | | Geschlecht | |
| […] | | | | | | […] | | | | […] | | | | | […] | | | | | | […] | |
| Unfallbetrieb (Name, Anschrift und Telefon-Nr. des Arbeitgebers, der Kita, der (Hoch-)Schule, der pflegebedürftigen Person) | | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | | |
| 1 Unfalltag | Uhrzeit | | | Unfallort | | | | | | Beginn der Arbeitszeit | | | | | Ende der Arbeitszeit | | | | | | | |
| […] | […] | | | […] | | | | | | […] | | | Uhr | | […] | | Uhr | | | | | |
| 2 Angaben der versicherten Person zum Unfallhergang und zur Tätigkeit, bei der der Unfall eingetreten ist | | | | | | | | | | | | | | | | | | | | | | |
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| 7 Erstdiagnose **- Freitext -** (Änderungen/Konkretisierungen **unverzüglich** nachmelden) | | | | | | | | | | | | | | | | | | **ICD 10** | | | |
| […] | | | | | | | | | | | | | | | | | | […] | | | |
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| 10 Ergeben sich aus Hergang und Befund Zweifel an einem Arbeitsunfall? Wenn ja, ist eine Kopie des HNO-Arztberichts auszuhändigen. | | | | | | | | | | | | | | | | | | | | | |
| Nein  Ja, weil | | | […] | | | | | | | | | | | | | | | | | | |
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| 11 **Art der Heilbehandlung** | | | | | | | | | | | | | | | | | | | | | |
| Allgemeine Heilbehandlung  Besondere Heilbehandlung, weil eingeleitet von D-Ärztin/D-Arzt (Bitte genaue Anschrift angeben.) | | | | | | | | | Ambulant  Stationär | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | |
| 12 **Weiterbehandlung erfolgt**  durch mich  durch andere Ärztin/anderen Arzt (auch Verlegung/Vorstellung), bitte Name und Anschrift angeben | | | | | | | | | | | | | | | | | | | | | |
| […] | | | | | | | | | | | | | | | | | | | | | |
| 13 **Beurteilung der Arbeitsfähigkeit**  Arbeitsfähig  Arbeitsunfähig ab […] | | | | | Voraussichtlich wieder arbeitsfähig ab […]  Voraussichtlich länger als 3 Monate arbeitsunfähig | | | | | | 14 **Ist die Zuziehung weiterer Ärztinnen/Ärzte zur Klärung der Diagnose und/oder Mitbehandlung erforderlich?**  Nein  Ja, zugezogen wird […] | | | | | | | | | | |
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| Datum | | Name und Anschrift (Stempel) der HNO-Ärztin/des HNO-Arztes | | | | | | | | | | Unterschrift der HNO-Ärztin/des HNO-Arztes | | | | | | | | | | |
| […] | | […] | | | | | | | | | | […] | | | | | | | | | | |

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| --- | --- | --- | --- |
| Name, Vorname: | Geburtsdatum: | Unfalltag: | Lfd. Nr. |
| […], […] | […] | […] | […] |

Weitere Ausführungen

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| […] |
| **Datenschutz:** Ich habe die Hinweise nach § 201 SGB VII gegeben. |