ReturntoWorkSA

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Work Capacity Certificate

A. Patient and employer details

Family name: _____ Given names: _____

Claim number (if known): _____ Employer name: _____

Date of birth: DD / MM / YYYY

B. Injury details and assessment

I examined you on: DD / MM / YYYY for injury(s)/condition(s) you stated occurred/developed on: DD / MM / YYYY

The stated cause was: _____

_____

The injury(s)/condition(s) you presented with is/are consistent with your stated cause(s): ☐ Yes ☐ No

☐ New condition ☐ Recurrence of pre-existing condition

My clinical diagnosis/es based on my examination of you and other available information is:

_____

Other comments/clinical findings: _____

_____

_____

C. Certification

In my opinion, you: (please tick whichever apply)

☐ have recovered from your injury/condition and are fit to return to your normal duties and hours on: DD / MM / YYYY

☐ some further treatment may be required

☐ are fit to perform suitable duties that accommodate your functional abilities from: DD / MM / YYYY to DD / MM / YYYY

☐ are medically unfit to undertake suitable duties while recovering from your injury for the period: DD / MM / YYYY to DD / MM / YYYY

Note: Certification based on functional capacity, not available duties.

Reason: _____

☐ I estimate you should have functional capacity to return to work in _____ days _____ weeks **OR** ☐ uncertain at this stage

(estimated timeframe will assist with planning for return to safe work)

I would like to review your progress on: DD / MM / YYYY or ☐ at your next medical consultation

Comments: _____

_____

D. Treatment plan

The following treatment plan is aimed at assisting your recovery and return to work:

_____

_____

I have referred you for the following clinical treatment:

☐ Medical specialist (Name & specialty) _____

☐ Psychologist (Name) _____

☐ Physiotherapist (Name) _____

☐ Other (Name & discipline) _____

E. Functional ability

Your ability to work is affected by **this** injury(s)/condition(s) as follows:
(please select applicable functions – blank fields indicate that limitations don't apply. Please include any impact of medications on function)

☐ No restrictions

Physical function	Can	With modifications	Cannot
Sitting:	☐	☐	☐
Standing/walking:	☐	☐	☐
Kneeling/squatting:	☐	☐	☐
Carrying/holding/lifting:	☐	☐	☐
Reaching above shoulder:	☐	☐	☐
Bending:	☐	☐	☐
Use of affected body part:	☐	☐	☐
Neck movement:	☐	☐	☐
Climbing steps/stairs/ladders:	☐	☐	☐
Driving:	☐	☐	☐

Comments
(e.g. details of capacity or limitations that will assist in identification of suitable duties)

Mental health function	Not affected	Partially affected	Affected
Attention/concentration:	☐	☐	☐
Memory (short term and/or long term):	☐	☐	☐
Judgement (ability to make decisions):	☐	☐	☐

☐ **Other functional considerations** - not listed above
(please provide details in comments section)

☐ I have prescribed medication(s) that could impact upon your ability to undertake some activities.

Details: _____

I recommend:

☐ A graduated increase in working hours over _____ weeks from _____ hours a day to your normal hours/ _____ hours a day

☐ Non-consecutive working days for a period of _____ days or _____ weeks

☐ I would like more information about the options available for your return to work

☐ I would like a copy of your recovery and return to work plan

F. Communication

Upon receipt of my patient's signed medical authority, I would like the:

☐ Case Manager to contact me once they have received this certificate (where a claim exists)

☐ Employer to contact me once they have received this certificate (where a claim exists)

Preferred contact method: ☐ phone ☐ email ☐ fax ☐ writing ☐ visit
(refer to section G for contact details)

G. Doctor's details

Doctor's name: _____

Address: _____

_____

_____

Phone: _____

Provider Number: _____

Email address: _____

Fax: _____

Signed: _____

Completion date: DD / MM / YYYY