Medical certificate of capacity - progress

Recommended for a maximum 28 days duration

Note: maximum referral period for rehabilitation treatment prior to review is initially 14 days, and then 28 days subsequent referrals to the same discipline.

- *Medical practitioner to retain a copy*
- *This certificate to be given to worker*

Worker details					
Surname:					
Given names:					
Date of birth:	/ /	Date of injury or disease:			
Gender:	Male ☐	Female ☐	Gender diverse ☐		
Address:					
Suburb:		State:		Postcode:	
Home number:		Work number:			
Mobile number:		Email address:			
Employer details					
Employer name:					
Address:					
Suburb:		State:		Postcode:	
Medical assessment					
Date of examination:	/ /	Time of examination:	AM ☐	PM ☐	
Clinical findings / diagnosis at this examination:					
Fitness for work (tick only those boxes which apply)					
In my opinion that as from the date of this statement, the worker is:					
Fit to return to ***pre-injury duties, no further treatment*** required.					☐
Fit to return to ***pre-injury duties, but requires further treatment***					☐
Fit to return to work for restricted hours / days from:					☐
/ / to / / (inclusive)	hours per day		hours per week		
Fit to return to work **<u>on restricted duties</u>** from:	/ / to / / (inclusive)				
Restricted duties:	Avoid prolonged standing / walking / sitting				☐
	Avoid squatting / kneeling / ladders / steps				☐
	No lifting anything heavier than:	5kg ☐	10kg ☐	15kg ☐	20 kg ☐ ☐
	Avoid repetitive use of affected body part				☐
	Avoid repetitive bending / lifting				☐
	Other (please specify)				☐
Totally unfit for work from:	/ / to / / (inclusive)				
I will review the worker (date of next appointment):	/ /				

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Injury management (tick only those boxes which apply)						
Medical practitioner / employer contact						
I have made contact with the employer and discussed alternative work options						☐
The worker will require more than three days off work, consequently I will be happy to discuss this further with the employer / insurer.						☐
Preferred contact days and time:	Monday ☐	Tuesday ☐	Wednesday ☐	Thursday ☐	Friday ☐	
	Saturday ☐	Sunday ☐	Times:	AM OR PM		
Medical management plan						
Treatment (specify):						☐
Medication (specify):						☐
Referred to specialist: (specialty/name):						☐
Date of appointment:	/ /	Time of appointment:		AM ☐ PM ☐		
Referred to hospital (specify):						☐
Referred to Allied Health Professional(s):						
Physiotherapist name:		Number of sessions recommended				
Chiropractor name:		Number of sessions recommended				
Other (specify):						
Vocational rehabilitation – options must be discussed with the worker						
Likely to be necessary, subject to review in		weeks				☐
I would like the employer / insurer to organise a referral and discuss with me.						☐
Preferred contact days and time:	Monday ☐	Tuesday ☐	Wednesday ☐	Thursday ☐	Friday ☐	
	Saturday ☐	Sunday ☐	Times:	AM OR PM		
Vocational rehabilitation referral:	May be necessary	☐	May not be necessary	☐		
Medical practitioner details						
Name:			Registration number:			
Address:			Suburb:			
State:		Postcode:		Work number:		
Fax number:		Email address:				
Signature:			Date:	/ /		