**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 **on restricted duties** 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) |
| Is this a FIRST and FINAL statement of fitness for work? | Yes | [ ]  | No | [ ]  |

|  |
| --- |
| **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: | **/     /** |