**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: | | | | | | | | **/     /** | | | | | | | |