**Occupational Rehabilitation Suitable Duties Plan**

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| **Patient Name: Claim #:** **D.O.B:**  **Assessment Date:**  **Occupation:** | **Attn:** June Khaw WorkCover Queensland june.khaw@btfinancialgroup.com **cc:** John Bougoure |
|  | **Employer:** |
| **Injury Date:** | **Nature / Location:** Disc bulge (L5-S1) |
| **Current Work Status:** Same employer | **Current Work Hours:**  **Normal Work Hours:** |
| **Present at work site assessment:** Mr Peterson, Anthony Doueal (KINNECT), John Bougoure (Racing Queensland Board), Rehab Coordinator name (title), partner's name (title) | |

| **Date** | **Days/Hours** | **Suitable Duties Plan** | |
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| Week 1 commencing: XX/XX/XX | XX hours XX days (Mon, Tues, Wed, Thurs, Fri)  Time: XX:XX am/pm - XX:XX am/pm  **OR** To be negotiated between the worker and employer / host employer.  Breaks:  If working over 5 hours a 30 minute lunch break (or breaks as per company policy) is included in the shift time. | **Duties to include:** | **Restrictions:** |
| **Recommendations:**  Apply manual handling techniques as prescribed: \_\_\_\_ EDIT/ADD TO THIS   * Maintain neutral spine postures; * Avoid twisting by keeping ‘nose over toes’; * Avoid over-reaching by moving close to tasks and ensure elbows are close to the body; * Maintain neutral wrist postures; * When ascending stairs use the un-injured leg to lead and when descending stairs use the injured leg to lead;   Other recommendations:   * Alternate \_\_\_\_ sitting / standing / walking every \_\_\_ minutes; * Perform stretches as prescribed and symptom management \_\_\_ ADD SPECIFIC FREQ/DURATION i.e. for up to 5 minutes every hour; * Maintain weekly contact with Anthony Doueal (KINNECT) and John Bougoure (Racing Queensland Board) to ensure coping with hours and duties. | |
| Week 2 commencing: XX/XX/XX | XX hours XX days (Mon, Tues, Wed, Thurs, Fri)  Time: XX:XX am/pm - XX:XX am/pm  **OR** To be negotiated between the worker and employer / host employer.    Breaks:  If working over 5 hours a 30 minute lunch break (or breaks as per company policy) is included in the shift time. | **Duties:** | **Restrictions:** |
| **Recommendations:**   * Perform stretches as prescribed and symptom management \_\_\_ ADD SPECIFIC FREQ/DURATION i.e. for up to 5 minutes every hour; * Continue as per all other recommendations above. | |
| Week 3 commencing: XX/XX/XX | XX hours XX days (Mon, Tues, Wed, Thurs, Fri)  Time: XX:XX am/pm - XX:XX am/pm  **OR** To be negotiated between the worker and employer / host employer.    Breaks:  If working over 5 hours a 30 minute lunch break (or breaks as per company policy) is included in the shift time. | **Duties:** | **Restrictions:** |
| **Recommendations:** | |
| Week 4 commencing: XX/XX/XX | XX hours XX days (Mon, Tues, Wed, Thurs, Fri)  Time: XX:XX am/pm - XX:XX am/pm  **OR** To be negotiated between the worker and employer / host employer.    Breaks:  If working over 5 hours a 30 minute lunch break (or breaks as per company policy) is included in the shift time. | **Duties:** | **Restrictions:** |
| **Recommendations:** | |
| Week 5 commencing: XX/XX/XX | XX hours XX days (Mon, Tues, Wed, Thurs, Fri)  Time: XX:XX am/pm - XX:XX am/pm  **OR** To be negotiated between the worker and employer / host employer.    Breaks:  If working over 5 hours a 30 minute lunch break (or breaks as per company policy) is included in the shift time. | **Duties:** | **Restrictions:** |
| **Recommendations:** | |
| Week 6 commencing: XX/XX/XX | XX hours XX days (Mon, Tues, Wed, Thurs, Fri)  Time: XX:XX am/pm - XX:XX am/pm  **OR** To be negotiated between the worker and employer / host employer.    Breaks:  If working over 5 hours a 30 minute lunch break (or breaks as per company policy) is included in the shift time. | **Duties:**: | **Restrictions:** |
| **Recommendations:** | |

If there are any questions or concerns please do not hesitate to contact me.

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Worker) **Only Sign this Plan If Completely Comfortable You Must Have Copy of The Plan** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | By signing this plan you agree to adhere to the PLAN. Please ensure you have a current medical certificate while on this plan. Please Notify your Supervisor / Rehabilitation Consultant of any concerns immediately. All medical appointments should be made outside of work hours. |
| (Specialist) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | Provide updates on progress to upgrade SDP, treatment requirements. |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dr Aubrey Dr Cindy Aubrey (General Practitioner) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | Provide updates on progress to upgrade SDP, treatment requirements. |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Employer) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | Monitor workers progress, adherence & attendance to the program. Advise Rehabilitation Consultant of any issues immediately. |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SELECT ONE (Employer, Supervisor, Manager, Rehabilitation Coordinator) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | Monitor workers progress, adherence & attendance to the program. Advise Rehabilitation Consultant of any issues immediately. |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Host Employer) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | Monitor workers progress, adherence & attendance to the program. Advise Rehabilitation Consultant of any issues immediately. |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Rehabilitation provider | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | Monitor the program, make any modifications required and update the employer/case manager/worker on any issues. |