Work capacity certificate – workers' compensation

Form 132M — Version 1

Workers' Compensation and Rehabilitation Act 2003

IMPORTANT INFORMATION : Work is an important part of recovery. In most cases an early return to work (or remaining at work) is beneficial for health and wellbeing. The treating practitioner's guidance increases the likelihood of positive return to work outcomes. A worker receiving continued support is three times more likely to regain their capacity to work. Consider the health benefits of work when certifying the patient's capacity.

Part A – Patient details

Name: Ben Johnson | Date of birth: 01/02/1965

Mobile number: 0 4 0 0 1 2 3 4 5 6 | Claim number: 01020305 | ☑ New claim ☐ Claim is report only

Occupation (if known): Excavator Operator | Patient's employer: Heavy rock earth moving

Part B – Injury details

Date of examination: 10/06/2016 | Patient's stated date of injury: 29.04.2016 | Patient was first seen at this practice/ hospital for this injury/disease on: 29/04/2016

The patient is/was suffering from *(List all work-related diagnoses. If symptoms only, tick "Provisional diagnosis")* ☐ Provisional diagnosis: Posteriolateral (R) Disk Buldge

Patient's stated mechanism of injury: Fall | Is this consistent with your clinical findings? ☑ Yes ☐ Unclear

Describe mechanism in detail: Jumping off Loader (IT14)

Pre-existing factors or condition aggravated *(if not previously supplied)*: Clinical-Depression

Part C – Treatment plan

Patient requires/d treatment from: 01/06/2016 to: 24/06/2016 | to be reviewed again on: 10/06/2016 | No further review ☐

Treatment: Physiotherapy / hydrotherapy / Exercise Physiology

I have prescribed medication that may impede safe work, travel or cognitive function ☐ No ☑ Yes

Referrals ☐ Diagnostic ☑ Allied Health ☐ Specialist/GP | Name/discipline: Exercise Physiology | Details *(specify)*: strength / Work Fitness / SDP

Part D – Capacity for work *(Choose one from the three options)*

○ The certified injury does not prevent a return to pre-injury duties. **Do not complete Part E. Go to Part F.**

○ If suitable duties available, can return to some form of work from: 12/06/2016

◉ No functional capacity for any type of work until: 08/06/2016

Complete below section if you certified no functional capacity for any type of work

If no functional capacity, state why? *(if no capacity for more than 7 days, the insurer may contact you to obtain more information)*

Patients nerve pain is too great. For the first week the patient will be treated medically only.

Estimated time to return to some form of work duties: 09.6.2016

Estimated time to return to full duties: 25.6.2016

Part E – Functional ability *(Optional for emergency medical practitioners/dental practitioners. Nurse practitioners not to complete.)*

No change since last certificate ☐

Certification should be based on what CAN be done, NOT available duties. Consider what the patient can do, either at work or home.

Function/task *(patient's usual functional ability)*	Is functional ability affected by injury/condition? **No**	**Yes**	Note any restrictions *(if relevant)*	What patient can do *(if "Yes" box ticked)*
Lower limb	◉	○		administration
Upper limb	◉	○		stacking, filing from intermittent sitting/standing positions
Hand function	◉	○		Moving loads shot distance (5minutes) no greater two kilos
Spinal function	○	◉	No twisting with compressive forces, no shock loads	Moving loads < 49.05kn from waist height only (5mins)
Cognition/psychosocial functioning	◉	○		
Driving a car	◉	○		
Operating machinery/heavy vehicle	○	◉	No operation while on valium. No operating on unstable surface	
Manual tasks	○	◉	Only when seated, no twisting or lateral bending	no movements over under 49.05kn
Other	◉	○		

Part F – Rehabilitation at work – return to work plan *(Optional for emergency medical practitioners/dental practitioners. Nurse practitioners not to complete.)*

What workplace modifications are required to facilitate return to work? *(e.g. work site assessment, psychosocial considerations)*

worksite assessment

Other considerations or factors that may affect recovery *(the insurer can arrange appropriate support)*

☑ I require a suitable duties program to be provided to me for approval

I have discussed injury requirements and return to work options with the patient and ☑ Employer ☐ Insurer ☐ Rehabilitation provider

Part G – Medical/dental/nurse practitioner details and statement *(or use practice/hospital stamp)*

I have discussed the information contained in this certificate with the patient. I have provided the clinical information in this certificate.

Name: Dr Love | Email: blove@hospital.gov.au

Practice/hospital: Brisbane Labourers Hospital | Phone: 0 7 4 2 1 0 4 2 1 0 | Date: 10/06/2016

Postal address: 123 Broken Rd, Brisbane | Signature:

Further information www.worksafe.qld.gov.au/medicalsupport
All enquiries (medical/dental/nurse practitioner, patient, employer) 1300 362 128

Queensland Government