

Workers' compensation - progress medical certificate

Progress medical certificate – recommended maximum 28 days duration

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

*Blue copy – for worker
White copy – doctors record*

SAMPLE ONLY

Workers' compensation - progress medical certificate

Recommended maximum 28 days duration

Please complete all sections of this form

1. Worker details

Surname: _____

Given name(s): _____

Address: _____

Telephone: _____

Date of injury or disease: / /

Date of birth: / /

2. Employer details

Name and address of worker's employer: _____

3. Medical assessment

Time and date of examination: am/pm / /

Clinical findings/diagnosis at this examination: _____

4. Fitness for Work *(tick only those boxes which apply)*

It is my opinion that as from the date of this certificate the worker is:
Fit

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)*
_____ hrs per day _____ hrs 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 5, 10, 15 or 20kg

Avoid repetitive use of affected body part

Avoid repetitive bending/lifting

Other restrictions: _____

Duties recommended/capable: _____

Totally unfit for work for _____ days
from / / to / / *(inclusive)*

I will review the worker (date of next appointment) / /

5. Injury management *(tick only those boxes which apply)*

Medical practitioner / employer contact

I have made contact with the employer and discussed alternative work options **OR**

The worker will require more than three days off work, consequently I will be happy to discuss this further with the employer/insurer. **Please note my preferred contact times*

Medical management plan

Medication (Please specify): _____

Physiotherapy/Chiropractor

Imaging

Other (Please specify) _____

Referred to Specialist

Specialist name: _____

Specialty: _____

Referred to hospital *(name of hospital)* _____

Surgery likely in the future

Other comments: _____

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. **Please note my preferred contact times.*

6. Medical practitioner details

Name: _____

Registration Number: _____

Address: _____

*Preferred Contact Times:

Day(s) _____ Time(s) _____

Telephone: _____

Facsimile: _____

Signature: _____

Date: / /

putting safety first >

