



## WorkCover WA - PROGRESS certificate of capacity

### 1. WORKER'S DETAILS

First name	<input type="text"/>	Last name	<input type="text"/>
Date of birth	<input type="text"/>	Claim no.	<input type="text"/>
Phone	<input type="text"/>	Email	<input type="text"/>
Address	<input type="text"/>		

### 2. EMPLOYER'S DETAILS

Employer's name	<input type="text"/>	Employer's phone	<input type="text"/>
Employer's address	<input type="text"/>		

### 3. MEDICAL ASSESSMENT

Date of this assessment	<input type="text"/>	Date of injury	<input type="text"/>
Diagnosis	<input type="text"/>		

### 4. PROGRESS REPORT

Activities/interventions	Actual outcome <i>(change in symptoms, function, activity and work participation)</i>	Still required?*	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No

\*(If management activities/interventions are still required, please also list them in Section 6 'Injury Management Plan')

Other factors appear to be impacting recovery and return to work

Comment

### 5. WORK CAPACITY

Worker's usual duties

Having considered the health benefits of work, I find this worker to have:

**full capacity for work** from   but requires further treatment

**some capacity for work**, from  to  performing:

pre-injury duties       modified or alternative duties       workplace modifications

pre-injury hours       modified hours of  hrs/day  days/wk

**no capacity for any work** from  to  *(outline clinical reason on next page)*

## 5. WORK CAPACITY (CONTINUED)

Worker has capacity to:

*(Please outline the worker's physical and/or psychosocial capacity – refer to explanatory notes for examples. Where there is no capacity for work, please provide clinical reasoning.)*

- lift up to  kg
- sit up to  mins
- stand up to  mins
- walk up to  m
- work below shoulder height


## 6. INJURY MANAGEMENT PLAN

Activities/interventions	Purpose/goal <i>(likely change in symptoms, function, activity and work participation)</i>

- I support the RTW program established by the employer/insurer/WRP dated
- I would like more information about available duties
- I would like to be involved in developing the RTW program
- Please engage a workplace rehabilitation provider *(If you have made a referral, provide name and contact details below)*

*Examples of injury management activities/interventions include:*

- further assessment - diagnostic imaging, medical specialist consults, worksite assessment*
- intervention - physiotherapy, clinical psychology, exercise physiology, prescribed medications, workplace mediation*
- return to work planning - identify suitable duties, establish return to work program*

## 7. NEXT REVIEW DATE

- I will review worker again on  *(if greater than 28 days, please provide clinical reasoning)*

Comments

## 8. MEDICAL PRACTITIONER'S DETAILS

Name	<input type="text"/>	AHPRA no. MED	<input type="text"/>
Address	<input type="text"/>	Email	<input type="text"/>
Phone	<input type="text"/>	Signature	<input type="text"/>
Fax	<input type="text"/>	Date	<input type="text"/>

*(Practice stamp – optional)*