WorkCoverWA

Form 3

WorkCover WA - FIRST certificate of capacity

1. WORKER'S DETAILS

First name	Susan	Last name	Smith
Date of birth	17/11/1964	Email	ssmith@email.com
Phone	08 9111 1111	Mobile	0411 111 111
Address	1 Westcoast Drive, Ocean Waves WA		

2. EMPLOYMENT DETAILS

Worker's job title	Registered nurse	Employer's name	Ocean Waves Public Hospital
Employer's address	1000 Hilltop Road, Ocean Waves WA		

3. CONSENT AUTHORITY

I consent to any medical practitioner who treats me (whether named on this certificate or not) to discuss my medical condition with my employer, insurer and other medical or allied health professionals for the purpose of my claim for workers' compensation and return to work options.

Worker's signature	S.Smith	Print name	Susan Smith
		Date	21/11/2013

4. WORKER'S DESCRIPTION OF INJURY

Date of injury	21/11/2013
What happened?	Man entered ED demanding prescription medication/drugs. Verbally assaulted. Threatened physically.
Worker's symptoms	Shock. 3 days later unable to go to ED/work – feeling anxious, nauseas, heart palpitations, sleep disturbances, nightmares.

5. MEDICAL ASSESSMENT

Date of this assessment	25/11/2013
Clinical findings	Reports anxiety, intrusive flashbacks of event, tearfulness, easily startled, difficulty getting to sleep, nightmares.
Diagnosis	Acute stress disorder / posttraumatic stress disorder?

The injury is consistent with worker's description of how injury occurred ☑ yes ☐ no ☐ uncertain

The injury is: ☑ a new condition ☐ a recurrence of a pre-existing condition

6. WORK CAPACITY

Worker's usual duties: Evaluate and record patient condition, assist medical procedures, bedside nursing, monitor vital signs

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 25/11/2013 to 02/12/2013 *(outline clinical reason below)*

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

Ms Smith requires psychological support to stabilise her condition. After 4 weeks of psychotherapy (e.g. exposure therapy and CBT), planning a gradual RTW may commence.

7. INJURY MANAGEMENT PLAN

Activities/interventions	Purpose/goal *(likely change in symptoms, function, activity and work participation)*
Clinical psychologist	Psychological counselling; exposure therapy and CBT; manage and reduce psychological symptoms.
RTW	Expected to commence RTW planning in 4 weeks.

I would like: ☑ more information about available duties ☐ a RTW program to be established
☐ to be involved in developing the RTW program

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*

8. NEXT REVIEW DATE

☐ Worker does not need to be reviewed again (FIRST and FINAL certificate of capacity)

☑ I will review worker again on 02/12/2013 *(if greater than 14 days, please provide clinical reasoning)*

Comments: ______

9. MEDICAL PRACTITIONER'S DETAILS

Name: Dr General Practitioner

AHPRA no. MED: 000111112

Address: 104 Practice Way
Ocean Waves WA

Email: gp@medicalpractice.email.au

Signature: G. Practitioner

Phone: (08) 9999 9911

Fax: (08) 9999 9912

(Practice stamp – optional)

Date: 25/11/2013