



WorkCover WA - FIRST certificate of capacity

1. WORKER'S DETAILS

First name	<input type="text" value="Roger"/>	Last name	<input type="text" value="Citizen"/>
Date of birth	<input type="text" value="02/05/1964"/>	Email	<input type="text" value="roger64@email.com"/>
Phone	<input type="text" value="08 6666 6666"/>	Mobile	<input type="text" value="0444 444 444"/>
Address	<input type="text" value="4 Sandcastle Way, Ocean Views WA 6666"/>		

2. EMPLOYMENT DETAILS

Worker's job title	<input type="text" value="Storeman"/>	Employer's name	<input type="text" value="ABC Paints"/>
Employer's address	<input type="text" value="123 Violet Drive, Wattle Grove WA 6668"/>		

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	<input type="text" value="RP Citizen"/>	Print name	<input type="text" value="Roger Citizen"/>
		Date	<input type="text" value="31/12/2013"/>

4. WORKER'S DESCRIPTION OF INJURY

Date of injury	<input type="text" value="29/12/2013"/>
What happened?	<input type="text" value="Forklift tipped over. He fell out and landed heavily on left side."/>
Worker's symptoms	<input type="text" value="Lower back pain; bruising to left arm, pelvis and leg."/>

5. MEDICAL ASSESSMENT

Date of this assessment	<input type="text" value="31/12/2014"/>
Clinical findings	<input type="text" value="Dull ache/spasm lumbar spine; positive radicular signs - left leg pain reinforced by foot dorsiflexion but not slump posture, tingling down leg - not foot, reduced back flexion (reach to mid-thigh); bruising to left arm, pelvis and leg"/>
Diagnosis	<input type="text" value="Soft tissue strain of lumbar spine; possible disc protrusion; contusions of left upper/lower limb and pelvis"/>
The injury is consistent with worker's description of how injury occurred	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> uncertain
The injury is:	<input checked="" type="checkbox"/> a new condition <input type="checkbox"/> a recurrence of a pre-existing condition

6. 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 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

Temporarily eliminate periods of prolonged sitting and standing, frequent bending/lifting and exposure to whole body vibrations (i.e. operating machinery when seated). Daily walks - walking capacity is 15 mins continuously, increase by 10% each week. Alternate postures regularly.

7. INJURY MANAGEMENT PLAN

Activities/interventions	Purpose/goal (likely change in symptoms, function, activity and work participation)
MRI lumbar spine	Define anatomy
Physiotherapy	Improved back mobility; core muscle activation; reinforce functional capacity
Daily walks (as above)	Maintain activity level; self-management strategy
Employer	Identify alternative duties; develop a return to work program
Medications	Naproxen 500mg bd; paracetamol PRN
I would like: <input checked="" type="checkbox"/> more information about available duties <input checked="" type="checkbox"/> a RTW program to be established <input checked="" type="checkbox"/> 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 (if greater than 14 days, please provide clinical reasoning)

Comments

9. MEDICAL PRACTITIONER'S DETAILS

Name AHPRA no. MED

Address Email

Phone Signature

Fax Date

(Practice stamp – optional)