



WorkCover WA - PROGRESS certificate of capacity

1. WORKER'S DETAILS

First name	<input type="text" value="Susan"/>	Last name	<input type="text" value="Smith"/>
Date of birth	<input type="text" value="17/11/1964"/>	Claim no.	<input type="text" value="11C02L34A56I78M"/>
Phone	<input type="text" value="08 9111 1111"/>	Email	<input type="text" value="ssmith@email.com"/>
Address	<input type="text" value="1 Westcoast Drive, Ocean Waves WA"/>		

2. EMPLOYER'S DETAILS

Employer's name	<input type="text" value="Ocean Waves Public Hospital"/>	Employer's phone	<input type="text" value="08 9111 9898"/>
Employer's address	<input type="text" value="1000 Hilltop Road, Ocean Waves WA"/>		

3. MEDICAL ASSESSMENT

Date of this assessment	<input type="text" value="17/01/2014"/>	Date of injury	<input type="text" value="21/11/2013"/>
Diagnosis	<input type="text" value="Post traumatic stress disorder"/>		

4. PROGRESS REPORT

Activities/interventions	Actual outcome <i>(change in symptoms, function, activity and work participation)</i>	Still required?*	
Clinical psychologist	Completed 10 sessions. Exposure therapy underway - increased RTW readiness.	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Workplace rehabilitation	Initial assessment completed; initial exposure therapy commenced, suitable duties identified.	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Case conference	Developed RTW program.	<input checked="" 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

Commence with afternoon start/finish times. Short breaks to implement psychological strategies when feeling anxious. Initial close supervisory support. Quiet work area - desk facing doorway. No initial work requiring deadlines - focus is workplace exposure. Commence RTW at 9 hrs/wk.

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; provide input into RTW program/work exposure
Workplace rehabilitation	Provide additional support for commencing RTW program.
RTW program	Reintroduce work; provide adequate support performing suitable duties; support recovery

- 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

8. NEXT REVIEW DATE

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

Comments

9. MEDICAL PRACTITIONER'S DETAILS

Name AHPRA no. MED

Address Email

Phone Signature

Fax Date

(Practice stamp – optional)