Form 4A

# WorkCover WA - PROGRESS certificate of capacity

## 1. WORKER'S DETAILS

| | | | |
|---|---|---|---|
| First name | Roger | Last name | Citizen |
| Date of birth | 02/05/1964 | Claim no. | Claim1234 |
| Phone | 0444 444 444 | Email | roger64@email.com |
| Address | 4 Sandcastle Way, Ocean Views WA 6666 | | |

## 2. EMPLOYER'S DETAILS

| | | | |
|---|---|---|---|
| Employer's name | ABC Paints | Employer's phone | 08 6266 6666 |
| Employer's address | 123 Violet Drive, Wattle Grove WA 6668 | | |

## 3. MEDICAL ASSESSMENT

| | | | |
|---|---|---|---|
| Date of this assessment | 13/01/2014 | Date of injury | 29/12/2013 |
| Diagnosis | L4/5 paracentral disc protrusion with radicular pain | | |

## 4. PROGRESS REPORT

| Activities/interventions | Actual outcome *(change in symptoms, function, activity and work participation)* | Still required?* | |
|---|---|---|---|
| MRI lumbar spine | Anatomy defined (see diagnosis) | ☐ Yes | ☑ No |
| Physiotherapy | Back mobility improved (reaches to knees); increased core stability and function | ☑ Yes | ☐ No |
| Daily walks | Capacity has increased to 20 mins continuous; helps with pain | ☑ Yes | ☐ No |
| Employer | Return to work program developed; recommenced work; supports in place | ☑ Yes | ☐ No |
| Medications | Effective pain relief PRN | ☑ Yes | ☐ No |
| | | ☐ Yes | ☐ 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: Pt concerns about nature of injury and impact on work

## 5. WORK CAPACITY

Worker's usual duties: operating forklifts; lifting up to 20kgs; moving stock around warehouse; collecting orders for dispatch

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 13/01/2014 to 27/01/2014 performing:

- ☐ pre-injury duties
- ☑ modified or alternative duties
- ☐ workplace modifications
- ☐ pre-injury hours
- ☑ modified hours of 4.5 hrs/day 5 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.)*

- [x] lift up to 6 kg
- [x] sit up to 15 mins
- [x] stand up to 15 mins
- [ ] walk up to m
- [ ] work below shoulder height

Continue as previously stated.
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 20 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)* |
|---|---|
| Employer | Provide reassurance of workplace support during recovery; continue RTW program (as outlined above) |
| Physiotherapy | Improved back mobility; core muscle activation; reassure re rate of recovery & functional capacity |
| Daily walks (as above) | Maintain activity level; self-management strategy |
| Medications | Naproxen 500mg bd; paracetamol PRN |
| | |
| | |

- [x] I support the RTW program established by the employer/insurer/WRP dated 06/01/2014
- [ ] 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

- [x] I will review worker again on 27/01/2014 *(if greater than 28 days, please provide clinical reasoning)*

Comments

## 9. MEDICAL PRACTITIONER'S DETAILS

Name: Dr G. Practitioner

Address: Ocean Views Medical Practice
5 Practice Way
Ocean Views WA 6666

Phone: 08 6666 1111

Fax: 08 6666 1112

*(Practice stamp – optional)*

AHPRA no. MED: 000123123

Email: gp@email.com

Signature: G. Practitioner

Date: 31/12/2013