ReturntoWorkSA

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Work Capacity Certificate

A. Patient and employer details

Family name: Given names:

Claim number (if known): Employer name:

Date of birth:

B. Injury details and assessment

I examined you on: for injury(s)/condition(s) you stated occurred/developed on:

The stated cause was:

The injury(s)/condition(s) you presented with is/are consistent with your stated cause(s): Yes No

New condition Recurrence of pre-existing condition

My clinical diagnosis/es based on my examination of you and other available information is:

Other comments/clinical findings:

C. Certification

In my opinion, you: (please tick whichever apply)

have recovered from your injury/condition and are fit to return to your normal duties and hours on:

some further treatment may be required

are fit to perform suitable duties that accommodate your functional abilities from: to

are medically unfit to undertake suitable duties while recovering from your injury for the period: to

Note: Certification based on functional capacity, not available duties.

Reason:

I estimate you should have functional capacity to return to work in days weeks **OR** uncertain at this stage

(estimated timeframe will assist with planning for return to safe work)

I would like to review your progress on: or at your next medical consultation

Comments:

D. Treatment plan

The following treatment plan is aimed at assisting your recovery and return to work:

I have referred you for the following clinical treatment:

Medical specialist (Name & specialty)

Psychologist (Name)

Physiotherapist (Name)

Other (Name & discipline)

E. Functional ability

Your ability to work is affected by **this** injury(s)/condition(s) as follows:
(please select applicable functions – blank fields indicate that limitations don't apply. Please include any impact of medications on function)

☐ No restrictions

Physical function	Can	With modifications	Cannot
Sitting:	○	○	○
Standing/walking:	○	○	○
Kneeling/squatting:	○	○	○
Carrying/holding/lifting:	○	○	○
Reaching above shoulder:	○	○	○
Bending:	○	○	○
Use of affected body part:	○	○	○
Neck movement:	○	○	○
Climbing steps/stairs/ladders:	○	○	○
Driving:	○	○	○

Mental health function	Not affected	Partially affected	Affected
Attention/concentration:	○	○	○
Memory (short term and/or long term):	○	○	○
Judgement (ability to make decisions):	○	○	○

Comments
(e.g. details of capacity or limitations that will assist in identification of suitable duties)

☐ **Other functional considerations** - not listed above
(please provide details in comments section)

☐ I have prescribed medication(s) that could impact upon your ability to undertake some activities.
Details: _____

I recommend:

☐ A graduated increase in working hours over ____ weeks from ____ hours a day to your normal hours/ ____ hours a day

☐ Non-consecutive working days for a period of ____ days or ____ weeks

☐ I would like more information about the options available for your return to work

☐ I would like a copy of your recovery and return to work plan

F. Communication

Upon receipt of my patient's signed medical authority, I would like the:

☐ Case Manager to contact me once they have received this certificate (where a claim exists)

☐ Employer to contact me once they have received this certificate (where a claim exists)

Preferred contact method: ☐ phone ☐ email ☐ fax ☐ writing ☐ visit
(refer to section G for contact details)

G. Doctor's details

Doctor's name: _____

Address: _____

Phone: _____

Provider Number: _____

Email address: _____

Fax: _____

Signed: _____

Completion date: _____