WorkCoverWA

Form 3

WorkCover WA - FIRST certificate of capacity

1. WORKER'S DETAILS

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

2. EMPLOYMENT DETAILS

Worker's job title	Storeman	Employer's name	ABC Paints
Employer's address	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	RP Citizen	Print name	Roger Citizen
		Date	31/12/2013

4. WORKER'S DESCRIPTION OF INJURY

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

5. MEDICAL ASSESSMENT

Date of this assessment	31/12/2013
Clinical findings	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	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 ☑ yes ☐ no ☐ uncertain

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

6. 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 31/12/2013 to 13/01/2014 performing:
  - ☐ pre-injury duties ☑ modified or alternative duties ☐ workplace modifications
  - ☐ pre-injury hours ☑ modified hours of 4 hrs/day 5 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 5 kg
- ☑ sit up to 15 mins
- ☑ stand up to 15 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: ☑ 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 13/01/2014 *(if greater than 14 days, please provide clinical reasoning)*

Comments: ______

9. MEDICAL PRACTITIONER'S DETAILS

Name: Dr G. Practitioner

AHPRA no. MED: 000123123

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

Email: gp@email.com

Signature: G. Practitioner

Phone: 08 6666 1111

Fax: 08 6666 1112

Date: 31/12/2013

(Practice stamp – optional)