ReturntoWorkSA

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Work Capacity Certificate

Version 2 effective 1 July 2017

A. Patient and employer details — Mandatory

Family name:

Given names:

Claim number (if known):

Employer name:

Date of birth:

B. Injury details and assessment — Mandatory

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

Is this a new injury/condition? ◯ Yes ◯ No

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

Other comments/clinical findings:

C. Certification — Mandatory

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:

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

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

Reason:

Note: Certification based on your functional ability, not available duties.

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 — Complete all fields relevant to your patient

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

Complete all fields relevant to your patient

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 - go to section G (Doctor's details)

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

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):	○	○	○

Other functional considerations - not listed above

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

F. Communication

Optional

Preferred contact method: phone email fax writing visit

G. Doctor's details

Mandatory

Doctor's name:

Address:

Phone:

Provider Number:

Email address:

Fax:

Signed:

Completion date: