

Form

Statement of fitness for work – Progress certificate

Recommended for a maximum 28 days duration

Note: maximum referral period for rehabilitation treatment prior to review is initially 14 days, and then 28 days subsequent referrals to the same discipline.

- *Medical practitioner to retain a copy*
- *This statement to be given to worker*

| | | | | | | | | | | |
|---|--|----|-----|--------------------------|----------------------------|--------------------------|-----------------------------|--------------------------|-----------------------------|--------------------------|
| 1. Worker details | | | | | | | | | | |
| Surname: | | | | | | | | | | |
| Given names: | | | | | | | | | | |
| Date of birth: | | | | | Date of injury or disease: | | | | | |
| Address: | | | | | | | | | | |
| Suburb: | | | | | State: | | | | Postcode: | |
| Home number: | | | | | Work number: | | | | | |
| Mobile number: | | | | | Email address: | | | | | |
| 2. Employer details | | | | | | | | | | |
| Employer name: | | | | | | | | | | |
| Address: | | | | | | | | | | |
| Suburb: | | | | | State: | | | | Postcode: | |
| 3. Medical assessment | | | | | | | | | | |
| Date of examination: | | | | | Time of examination: | | AM <input type="checkbox"/> | | PM <input type="checkbox"/> | |
| Clinical findings / diagnosis at this examination: | | | | | | | | | | |
| | | | | | | | | | | |
| 4. Fitness for work (tick only those boxes which apply) | | | | | | | | | | |
| In my opinion that as from the date of this statement, the worker is: | | | | | | | | | | |
| Fit to return to pre-injury duties, no further treatment required. | | | | | | | | | <input type="checkbox"/> | |
| Fit to return to pre-injury duties , but requires further treatment | | | | | | | | | <input type="checkbox"/> | |
| Fit to return to work for restricted hours / days from: | | | | | | | | | <input type="checkbox"/> | |
| | | to | | (inclusive) | | hours per day | | hours per week | | |
| Fit to return to work on restricted duties from: | | | | | to | | (inclusive) | | | |
| Restricted duties: | Avoid prolonged standing / walking / sitting | | | | | | | | <input type="checkbox"/> | |
| | Avoid squatting / kneeling / ladders / steps | | | | | | | | <input type="checkbox"/> | |
| | No lifting anything heavier than: | | 5kg | <input type="checkbox"/> | 10kg | <input type="checkbox"/> | 15kg | <input type="checkbox"/> | 20kg | <input type="checkbox"/> |
| | Avoid repetitive use of affected body part | | | | | | | | <input type="checkbox"/> | |
| | Avoid repetitive bending / lifting | | | | | | | | <input type="checkbox"/> | |
| | Other (please specify) | | | | | | | | <input type="checkbox"/> | |
| Totally unfit for work from: | | | | | to | | (inclusive) | | <input type="checkbox"/> | |
| I will review the worker (date of next appointment): | | | | | | | | | | |

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|--|-----------------------------------|----------------------------------|------------------------------------|-----------------------------------|---------------------------------|-----------------------------|-----------------------------|--|--------------------------|--------------------------|
| 5. Injury management (tick only those boxes which apply) | | | | | | | | | | |
| Medical practitioner / employer contact | | | | | | | | | | |
| I have made contact with the employer and discussed alternative work options | | | | | | | | | <input type="checkbox"/> | |
| The worker will require more than three days off work, consequently I will be happy to discuss this further with the employer / insurer. | | | | | | | | | <input type="checkbox"/> | |
| Preferred contact days and time: | Monday <input type="checkbox"/> | Tuesday <input type="checkbox"/> | Wednesday <input type="checkbox"/> | Thursday <input type="checkbox"/> | Friday <input type="checkbox"/> | | | | | |
| | Saturday <input type="checkbox"/> | Sunday <input type="checkbox"/> | Times: | AM | OR | PM | | | | |
| Medical management plan | | | | | | | | | | |
| Treatment (specify): | | | | | | | | | <input type="checkbox"/> | |
| Medication (specify): | | | | | | | | | <input type="checkbox"/> | |
| Referred to specialist: (specialty/name): | | | | | | | | | <input type="checkbox"/> | |
| Date of appointment: | | | Time of appointment; | | | AM <input type="checkbox"/> | PM <input type="checkbox"/> | | | |
| Referred to hospital (specify): | | | | | | | | | <input type="checkbox"/> | |
| Referred to Allied Health Professional(s): | | | | | | | | | | |
| Physiotherapist name: | | | | | Number of sessions recommended | | | | | |
| Chiropractor name: | | | | | Number of sessions recommended | | | | | |
| Other (specify): | | | | | | | | | | |
| Vocational rehabilitation – options must be discussed with the worker | | | | | | | | | | |
| Likely to be necessary, subject to review in | | | weeks | | | | | | | <input type="checkbox"/> |
| I would like the employer / insurer to organise a referral and discuss with me. | | | | | | | | | <input type="checkbox"/> | |
| Preferred contact days and time: | Monday <input type="checkbox"/> | Tuesday <input type="checkbox"/> | Wednesday <input type="checkbox"/> | Thursday <input type="checkbox"/> | Friday <input type="checkbox"/> | | | | | |
| | Saturday <input type="checkbox"/> | Sunday <input type="checkbox"/> | Times: | AM | OR | PM | | | | |
| Medical practitioner details | | | | | | | | | | |
| Name: | | | | | Registration number: | | | | | |
| Address: | | | | | Suburb: | | | | | |
| State: | | | Postcode: | | | Work number: | | | | |
| Fax number: | | | Email address: | | | | | | | |
| Signature: | | | | | Date: | | | | | |