CLAIM ENQUIRIES
WorkCover Queensland 1300 362 128
Self insurance or other enquiries 1300 361 235

Queensland
Workers' compensation medical certificate

For general information about workers' compensation visit www.qcomp.com.au

86.R
VERSION 4

PARTS A AND E OF THIS MEDICAL CERTIFICATE COMPRISE AN APPROVED FORM UNDER THE *WORKERS' COMPENSATION AND REHABILITATION ACT 2003*

Tick ☑ if applicable, and fill in the information as requested.

☐ New claim

Claim number

PART A - Worker's details

I certify that on ___/___/___ I attended to (given names) _____

(surname) _____ (DOB) ___/___/___

Worker's daytime contact phone number _____

Worker's employer name _____

The worker is/was suffering from (list all medical/dental diagnoses relevant to the claim):

Diagnosis: _____

☐ This is a provisional diagnosis (**if provisional complete Part B**)

Worker was first seen at this practice/hospital for this injury/disease on ___/___/___

Worker stated date of injury ___/___/___

Worker's stated cause of injury (if not previously supplied):

_____

Injury/disease is consistent with worker's description of cause: ☐ Yes ☐ Uncertain

Detail any pre-existing factors or condition aggravated by the event (if not previously supplied):

_____

Worker's capacity for work (not only pre-injury duties)

Please consider the *"health benefits of work"* when certifying the worker's capacity

☐ To return to normal duties from ___/___/___

☐ For suitable duties from ___/___/___ to ___/___/___ (**complete Part D**)

☐ No capability for any type of work ___/___/___ to ___/___/___ (**complete Part C**)

Estimated time to return to some form of work duties: _____ ☐ days ☐ weeks ☐ unsure

Medical management

☐ Worker will require treatment from ___/___/___ to ___/___/___ (**complete Part C**)

☐ Worker will be reviewed again on ___/___/___ ☐ No further review required

PART B - Diagnostic plan

I have ordered: ☐ Diagnostic imaging ☐ Pathology ☐ Other investigations

Details: _____

This form was approved by the Chief Executive Officer of Q-COMP, the Workers' Compensation Regulatory Authority, on 4 June 2012, pursuant to section 586 of the Workers' Compensation and Rehabilitation Act 2003. PRIVACY STATEMENT – Under the Workers' Compensation and Rehabilitation Act 2003 and earlier Queensland workers' compensation legislation, the workers' compensation insurer is authorised to collect the information on this form to process the claimant's application for compensation. Some or all of the information contained in this form may be disclosed to the claimant's employer, another insurer, medical or allied health providers or any other workers' compensation authority in any jurisdiction.

PART C - Medical management plan

Treatment: _____

Medication prescribed: _____

Referred to specialist (specialty/name): _____

Referred to allied health professional (discipline/name): _____

Detail (specify): _____

I would like the insurer to arrange a case conference with (tick more than one if appropriate)

☐ Treating practitioner ☐ Treating Specialist ☐ Treating Allied Health ☐ Employer

☐ Employer has been contacted

☐ I would like the insurer to contact me

Further information:

_____

PART D - Rehabilitation and return to work plan

☐ Approval is given for a suitable duties program with the following guidelines

	No	Occasional	Frequent	Comments
Lifting: weight limit ___ kg	☐	☐	☐	_____
Bending/twisting/squatting	☐	☐	☐	_____
Standing/sitting	☐	☐	☐	_____
Use of injured hand/arm	☐	☐	☐	_____
Pushing/pulling	☐	☐	☐	_____
Operating machinery /heavy vehicle	☐	☐	☐	_____
Driving a car	☐	☐	☐	_____

☐ Keep wound clean and dry

Other considerations (specify): _____

Restricted hours/days (specify): _____

☐ I require a suitable duties program to be provided to me for approval

PART E - Medical/Dental practitioner details (please print clearly or use practice or hospital stamp)

Doctor's name: _____ Practice/hospital name: _____

Postal address: _____

Preferred method of contact: ☐ Ph: _____ day(s)/time(s) _____

☐ Fax: _____ ☐ Email: _____

Signature: _____ Date: ___/___/___

Practice/hospital stamp here

Original signed copy – Insurer | Second copy – Employer | Third copy – Worker | Fourth copy – Medical/Dental Practitioner