NSW GOVERNMENT | WorkCover

WorkCover NSW – certificate of capacity

Please ensure all sections are completed. Tick if this is the initial certificate for this claim ☒

PART A – MAY BE COMPLETED BY PATIENT

Patient's first name: Christopher Last name: Markham

Date of birth (DD/MM/YYYY): 20 May 1969

Patient's address: 109/4 Rosewater Circuit Breakfast Point NSW 2137

Claim number: 2328631

Medicare number: 2331 00685 41 Exp 15 May 2023

Shaded areas to be completed for initial certificate only

Patient's occupation/job title: Sales

Employer's name and contact details: Australian Automotive Group

I consent to my treating medical practitioner, my employer, the insurer, other treating practitioners, workplace rehabilitation providers and WorkCover exchanging information for the purposes of managing my injury and workers compensation claim. I understand that this information will be used by WorkCover and insurers to fulfil their functions under the workers compensation legislation.

Signature of patient

Date (DD/MM/YYYY) 08 / 10 / 2019

PART B – TO BE COMPLETED BY NOMINATED TREATING DOCTOR OR TREATING SPECIALIST MEDICAL PRACTITIONER

MEDICAL CERTIFICATION

Diagnosis of work related injury/disease: RIGHT knee tear in the posterior horn of the medial meniscus.

Patient stated date of injury: 05/06/2019

Shaded areas to be completed for initial certificate only

Patient was first seen at this practice/hospital for this injury/disease on: 25/06/2019

Injury/disease is consistent with patient's description of cause ☐ Yes ☐ No ☐ Uncertain

How is the injury/disease related to work?: slipped on painted surface on driveway ramp

Detail any pre-existing factors which may be relevant to this condition: nil

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Claimant name: Mr Christopher Markham Claim number: 2328631

MANAGEMENT PLAN FOR THIS PERIOD

Treatment/medication type and duration (Duration: short term = < 6 weeks, medium term = 6–12 weeks, long term = > 12 weeks):
panadeine forte prn, endone prn.

Referral to another health care provider (provide details of provider and service requested, duration and frequency when relevant):
Medisports Clinic, 83553999 for physiotherapy weekly 8 weeks.
Request approval for MRI RT knee clinical exam suggests meniscal tear
16/08/2019pain increasing. MRI confirms tear in the posterior horn of the RT medial meniscus. Refer to Dr Simon Tan. Orthopaedic surgeon for arthroscopic repair. Rest 2 weeks then rv with view to return to light duties..Continue Physiotherapy. add NSAID.
23/08/2019 ongoing pain, renal impairment. stop NSAID. Ref Dr Leo Pinczewski Orthopaedic surgeon appt 29/08/2019
29/08/2019 awaiting arthroscopic repair
18/09/2019 meniscal repair
23/09/2019 return to work
04/10/2019 increasing knee pain - RICE, mobic 15mg qd, physio, await rv Dr Pincxewski 18/10/2019

CAPACITY FOR EMPLOYMENT (Please consider the health benefits of work when completing this section)

Do you require a copy of the position description/work duties? ☐ Yes ☒ No

Patient:

☐ is fit for pre-injury duties

☒ has capacity for some type of employment from 23/09/2019 to 03/10/2019 (dates)
for 7.5 hours/day 5 days/week

☒ has no current work capacity for any employment from 04/10/2019 to 22/10/2019 (dates)

If no current work capacity, estimated time to return to any type of employment: 2W

Factors delaying recovery:

Do you recommend referral to workplace rehabilitation provider? ☐ Yes ☒ No

Capacity – If the patient is fit for pre-injury duties this section does not need to be completed. For all other patients please consider activities of daily living currently being performed.

Lifting/carrying capacity:

Sitting tolerance:

Standing tolerance:

Pushing/pulling ability:

Bending/twisting/squatting ability:

Driving ability:

Other (please specify) *eg psychological considerations, keep wound clean and dry*:

Next review date: 22/10/2019 (if greater than 28 days, please provide clinical reasoning)

Comments:

TREATING MEDICAL PRACTITIONER DETAILS

☒ Please tick if you agree to be the nominated treating doctor for the ongoing management of this worker's injury and return to work.

I certify that I am the ☒ nominated treating doctor or ☐ treating specialist (please tick) and I have examined this patient. The information and medical opinions contained in this certificate of capacity are, to the best of my knowledge, true and correct.

Signature of practitioner

Date (DD/MM/YYYY) 09 / 10 / 2019

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Practitioner's name: Dr Andrew Gowers
Address: Holdsworth House Medical Practice
Level 3, 26 College St Sydney NSW 2010
Telephone number: 02 9331 7228
Provider Number: 201775FF

Practice stamp (if available):

Dr Andrew GOWERS
Provider Number: 201775FF
Holdsworth House Medical Practice
Level 3, 26 College Street, Sydney NSW 2010
Ph: (02) 9331 7228 Fax: (02) 9360 9232
Andrew.Gowers@holdsworthhouse.com.au

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PART C – TO BE COMPLETED BY THE WORKER PRIOR TO SENDING TO THE EMPLOYER OR INSURER (this does not involve the nominated treating doctor/treating specialist)

WORKER DECLERATION

Worker's first name: Christopher Last name: Markham

Date of birth (DD/MM/YYYY): 20 May 1969

Worker's address: 109/4 Rosewater Circuit Breakfast Point NSW 2137

Claim number: 2328631

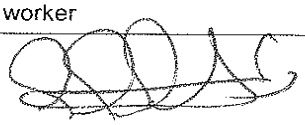
I [ ] have [ ] have not (tick appropriate box)

engaged in any form of paid employment, self employment or voluntary work for which I have received or am entitled to receive payment in money or otherwise since the last certificate was provided, that I have not yet declared to the insurer.

If you have been engaged in any form of paid employment or voluntary work, please provide details below (or attach when you forward this certificate to your employer or insurer).

I declare that the details I have given on this declaration are true and correct, knowing that false declarations are punishable by law.

Signature of worker



Date (DD/MM/YYYY) 10 10 2019

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