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RE: 2890317 - Mr Dale Kam - Case Conferences For 29 June 2020

Joseph Squadrito [joseph@beneco.com.au]

Sent: Monday, 29 June 2020 8:37 PM**To:** Lauren Tu'ipulotu [Lauren@beneco.com.au]; David Berlusconi; Lyndal Brodie [L.Brodie@eml.com.au]**Cc:** Lyndal Brodie [piclaims@icare.nsw.gov.au]**Attachments:** [Cert Cap 29.6.2020 - 26.7.~1.pdf \(186 KB\)](#); [Cert Cap 27.7.2020 - 30.6.~1.pdf \(342 KB\)](#); [physiotherapist referral.pdf \(523 KB\)](#)

Good afternoon All,

Today I attended two appointments for Mr Kam, the NTS review with Dr Alice Chang, and the NTD review with Dr Chitra, below is a summary of that discussed.

Mr Kam was polite, but very suspicious of our attendance and questioned our purpose despite being told of our role in the initial assessment with Lauren. He presented to be a little distrusting with minimal eye contact.

NTS Case conference

- Dr Chang removed the stitches and reported that she was pleased with how the wound was healing.
- Mr Kam attended on time, and was wearing his cam boot. He was driven by his wife as he reported difficulty in driving with the boot on.
- It was observed that there was some clear yellow liquid coming from the wound, however the NTS reported that this was the passing infection.
- It was confirmed that the surgery was successful and that all the fixation pieces were removed.
- Treatment was discussed and it was confirmed that Mr Kam could commence physiotherapy immediately. A referral form was provided (as attached).
- Beneco discussed return to work and Dr Chang reported that this would be more appropriate in 4 weeks as she wanted Mr Kam to commence physiotherapy.
- Beneco discussed the physical demands and reported that the sedentary nature of the suitable duties and it was confirmed that the travel and transition to the office was not something she was willing to consider at 2 weeks post op.
- Beneco inquired whether working from home would be supported, and it was agreed that this would be at reduced hours to see how he transitioned.
- Prognosis to PID's was confirmed at 8-12 weeks depending on the wound healing.
- Mr Kam reported to be passionate about motor cycle riding, Beneco asked a timeframe in returning to this and Dr Chang confirmed that this would be reviewed following his successful return to work.
- Beneco inquired about the use of the cam boot and the NTS confirmed that she wanted to see a reduction in his use of the boot.
- Beneco asked if there were any barriers precluding his
- The NTS wrote a certificate of capacity certifying Mr Kam fit to work from home for 4 hours, 5 days per week, with a review in 4 weeks.

NTD case conference

- Mr Kam was late for the review as he was confused with the time of the case conference.
- Upon arrival Mr Kam was not wearing his cam boot he appeared to ambulate confidently but slowly. He reported that his pain was minimal.
- The NTD asked to speak with Mr Kam Independently and she conducted her assessment. Following this she welcomed Beneco into the room for the discussion.
- A summary of the case conference was provided and Mr Kam reported that he would continue to improve now he was allowed out of the boot. He reported that he would commence Physio, but was confident he would be ok without it.
- Beneco highlighted the risks of not attending treatment and strongly encouraged it, this was supported by the NTD.
- The NTD encouraged Mr Kam to return in two week to further review his certification with view to increase his hours or permit his return to the office he Mr Kam was confident in doing so.
- Return to work barriers were discussed and Mr Kam reported that he saw no long term concerns in returning to the office. He reported that the frequent use of the stairs would be an issue upon his return.
- Beneco confirmed that strategies would be put in place to ensure assistance would be provided in the early stages.
- Following the case conference an appointment was scheduled to commence with physiotherapy tomorrow afternoon.

Actions:

1. Mr Kam to commence working suitable duties on a WFH basis. David, please let me know if you would like me to reach out to tony onsite, or if you would prefer to make that contact?
2. Beneco to circulate recovery at work plan and circulate to all stakeholders.
3. Beneco to facilitate NTD case conference in a fortnight with view to increase his capacity for work towards pre-injury levels.

As always, if there are any further questions please do not hesitate to contact me on 0432 033 972.

Kind regards,



Joseph Squadrito
Principal

B.App.Sc (Ex&SpSc) ESSAM AEP

M [0432 033 972](tel:0432 033 972)

T [02 8205 7701](tel:02 8205 7701)

F [02 8065 1051](tel:02 8065 1051)

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From: Lauren Tu'ipulotu <lauren@beneco.com.au>

Sent: Thursday, 25 June 2020 6:01 PM

To: David Berlusconi <dberlusconi@aag.com.au>; Lyndal Brodie <L.Brodie@eml.com.au>

Cc: Lyndal Brodie <piclaims@icare.nsw.gov.au>; Joseph Squadrito <joseph@beneco.com.au>

Subject: 2890317 - Mr Dale Kam - Case Conferences For 29 June 2020

Dear David and Lyndal,

With reference to Mr Dale Kam, Beneco has scheduled both a NTS Case Conference and NTD Case COncference for Monday 29 June 2020.

As I will be on leave next week Joseph will be attending these and his details are below:

Joseph Squadrito
Principal

B.App.Sc (Ex&SpSc) ESSAM AEP

M [0432 033 972](tel:0432 033 972)

T [02 8205 7701](tel:02 8205 7701)

F [02 8065 1051](tel:02 8065 1051)

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The agendas for each are as follows:

NTS Case Conference:

- Review the outcome of surgery
- Discuss what treatment is required and obtain a referral for this or details to request from the NTD
- Revision of the demands of the pre-injury duties and suitable duties.
- Confirm prognosis for suitable duties given low physical demands and ability to work from home
- Confirm prognosis for pre-injury duties
- Discussion about barriers related to return to work
- Discussion regarding current symptoms and management

NTD Case Conference:

- Review the outcome of the NTS Case Conference held on 29 June 2020
- Confirm treatment plan and obtain referral if required
- Discussion regarding current symptoms and management
- Revision of the demands of the pre-injury duties and suitable duties
- Confirm prognosis from NTS and obtain agreement
- Discussion about barriers related to return to work

- Review certification and possible upgrade in capacity

Should you have any further questions or anything to add, please do not hesitate to contact Joseph.

Regards,



Lauren Tu'ipulotu
Leading Consultant (Quality and Development)
B.App.Sc (OT)
Occupational Therapist

M 0477 008 108
T 1300 023 632
F 1300 023 633
www.beneco.com.au



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Certificate of capacity/ certificate of fitness



State Insurance
Regulatory Authority

For use with workers compensation and Compulsory Third Party (CTP) motor accident injury claims.

☐ CTP ☒ Workers compensation

For CTP claims: 'Certificate of fitness' means 'certificate of fitness for work'. This certificate should be completed whether the person was employed at the time of the accident or not.

☐ Tick if this is the initial certificate for this claim.

Section 1: To be completed by the injured person or treating medical practitioner

First name Dale		Last name Kam	
Date of birth (DD/MM/YYYY) []	Telephone number []		
Address (must be residential address - not PO Box) []		Suburb []	
State []	Postcode []	Claim number []	Medicare number []
Occupation/job title []		Employer's name and contact details (if applicable) []	

Injured person's consent

I consent to my treating medical practitioner, my employer (optional for CTP claims), the insurer, other medical practitioners or health related practitioners (whether consulting, treating or examining), workplace rehabilitation providers and SIRA exchanging information for the purpose of managing my injury and workers compensation/motor accident injury claim.

I understand this information will be used by SIRA and insurers to fulfill their functions under the motor accident insurance and workers compensation legislation.

Signature []	Date (DD/MM/YYYY) []
------------------	--------------------------

Section 2: To be completed by treating medical practitioner

Medical certification

Diagnosis of work related injury/disease or motor accident related injury(ies)

Left ankle fracture dislocation

Person's stated date of injury/accident (DD/MM/YYYY) 9/3/2020

Shaded areas to be completed for initial certificate only

Person was first seen at this practice/hospital for this injury on (DD/MM/YYYY)

[]

Injury is consistent with person's description of cause

☒ Yes ☐ No ☐ Uncertain

How is the injury related to work or the motor vehicle accident?

[]

Detail any pre-existing factors which may be relevant to this condition or injury(ies)

[]

First name Last name Claim number

Management plan for this period

Treatment/medication type and duration

physiotherapy, wound monitoring

Referral to another health service or rehabilitation provider (include details of provider type and service requested, duration and frequency when relevant)

physiotherapy

Capacity for activities – If the person has capacity for pre-injury work this section does not need to be completed. For all others please consider activities of daily living currently being performed.

Lifting/carrying capacity

5kg

Sitting tolerance

unlimited

Standing tolerance

as tolerated

Pushing/pulling ability

as tolerated

Bending/twisting/squatting ability

as tolerated

Driving ability

as tolerated

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

Next review date (DD/MM/YYYY)

4 weeks

(if greater than 28 days, please provide clinical reasoning)

Comments

~~for review in 4 weeks to review returning to work~~

work from home for now



Capacity for work (please consider the health benefits of good work when completing this section).

Where the word 'capacity' appears below it should be read as 'fitness for work' when the certificate is completed in a motor accident injury claim.

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

☐ is fit for pre-injury work from

Date (DD/MM/YYYY)

☒ has capacity for some type of work from

29/6/2020

to 26/7/2020

for 4 hours/day 5 days/week

☐ has no current capacity for any work from

to

If no current capacity for work, estimated time to return to any type of employment

4 weeks

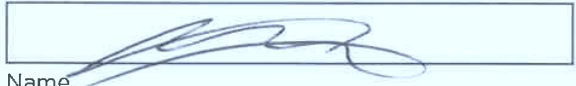
Factors affecting recovery

involvement of a rehab consultant to facilitate returning to work will likely improve outcome.

First name	Last name	Claim number

Treating medical practitioner details

I certify that I am the treating medical practitioner and I have examined this person. The information and medical opinions contained in this certificate are, to the best of my knowledge, true and correct.

Signature	Date (DD/MM/YYYY)
	29/6/2020
Name	
Alice Chang	
Address	
PO Box 689	
Suburb	State
Five Dock	NSW
Postcode	
2046	
Telephone number	Provider number
02 91606296	415066YF

☐ I agree to be the nominated treating doctor for the ongoing management of this person's injury, treatment and recovery at/return to work (tick if you consent).

Section 3: Employment declaration (not to be completed by the treating medical practitioner)

This section is to be completed by the person prior to sending to the insurer (or employer).

First name	Last name

☐ I have ☐ I 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 so, please provide details below.

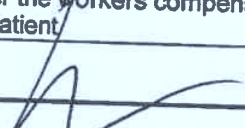
I declare that the details I have given on this declaration are true and correct, knowing that false declarations are punishable by law.

Signature	Date (DD/MM/YYYY)

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	Last name
DALE	KAM
Date of birth (DD/MM/YYYY)	Telephone number
03/05/1960	(02)9626-6602
Patient's address	
5 Clinton St QUAKERS HILL 2763	
Claim number	
Medicare number	
2020895421	
Shaded areas to be completed for initial certificate only	
Patient's occupation/job title	
Automotive service advisor	
Employer's name and contact details	
Ryde Hyundai	
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 management 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)
	

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

MEDICAL CERTIFICATION

Diagnosis of work related injury/disease	
Left ankle fracture - requiring open reduction , internal fixation and syndesmosis stabilisation on 24/3/2020	
Patient stated date of injury	9/3/2020
Shaded areas to be completed for initial certificate only	
Patient was first seen at this practice/hospital for this injury/disease on	1/4/2020
Injury/disease is consistent with patient's description of cause	
How is the injury/disease related to work?	
On 9/3/2020 while at work while walking down the stairs , twisted of left ankle , lost his balance and fractured his left ankle Colleague helped him ,	
Detail any pre-existing factors which may be relevant to this condition	

Address

206 Farnham Rd
Quakers Hill 2763

Telephone number

0296266733

Fax number

0296269733

Provider number

2931117T

Page 2 of 3

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)

WORK DECLARATION**Worker's first name**

DALE

Last name

KAM

Date of birth (DD/MM/YYYY)

03/05/1960

Worker's address

5 Clinton St
QUAKERS HILL 2763

Claim number

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)**

MANAGEMENT PLAN FOR THIS PERIOD

Treatment/medication type and duration (Duration: short term = < 6 weeks, medium term = 6-12 weeks, long term = > 12 weeks)

analgesics, presented to Concord hospital, operated at Strathfield Private on 24/3/2020
left knee arthroscopy, open reduction, internal fixation and syndesmosis stabilisation, follow up Dr Alice Chang
6/4/2020 left ankle debridement 5/5/2020

discharged home with hospital in home services
WBAT in camboot
on baxter pump for antibiotics through PICC line
grew staph, pseudomonas, Finegoldia magna
iv tazocin infusers until hardware removal 16/6 and 3 days after

done

ROS done today at Dr Alice's rooms
to commence Physio

Referral to another health care provider (provide details of provider and service requested, duration and frequency when relevant)

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?

Patient:

☐ is fit for pre-injury duties

☐ has capacity for some type of employment from 30/6/2020

for 4 hours/days 5 days/weeks

☐ has no current work capacity for any employment from

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

Factors delaying recovery

Do you recommend referral to workplace rehabilitation provider?

to 27/7/2020

to

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

5kg

Sitting tolerance

as tolerated

Standing tolerance

as tolerated

Pushing/pulling ability

as tolerated

Bending/twisting/squatting ability

as tolerated

Driving ability

as tolerated

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

Next review date 27/7/2020

(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 and I have examined this patient/ The information and medical opinions contained in this certificate of capacity are, to the best knowledge, true and correct.

Signature

Date (DD/MM/YYYY)

29/6/2020

Name

(practice stamp if available)

Main Surgery

Chitra Sivaramamoorthy

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Dr Alice Chang BASc, MBBS, FRACS(Ortho)

Orthopaedic Surgeon

Prov. No: 4150664Y

Trauma, Foot and Ankle Surgery

Adult and Paediatric

Tel: 1300 372 542

Fax: 02 9166 9948

info@DrAliceChang.com

www.DrAliceChang.com

PO Box 689 Five Dock NSW 2046

Dear : Physio

Re : Dale Kam

Thank you for seeing this patient.

Diagnosis : (L) ankle # dislocation

Surgery : ORIF

Treatment Required:

☒ Strengthening

☒ Gait Retraining

☒ Range of Motion Exercise

☒ Proprioception retraining Exercise

☒ Weight Bearing : _____

☐ Orthosis/Aid : _____

*Gentle active ROM 2x
then no restriction*

Other : _____

Please do not hesitate to contact me, with any query.

With warm regards,

Dr. Alice Chang