AUSTRALIAN AUTOMOTIVE GROUP – INCIDENT REPORT FORM

INCIDENT REPORT FORM

PART A - INJURED WORKERS DETAILS

Name: MATTHEW WALSH Gender: ☑ Male ☐ Female

Position title: Tech Date of Birth: 14-3-1994.

Site location employed at: City ford Rockdale Service department. 12 Arncliffe st Arncliffe 2205 Shift time: full time 8-4:06 m-f.

PART B – PERSON COMPLETING THIS FORM

Full Name: FRED JEANES.

Position: Service MANAGER

Relationship to the Employee: Boss.

Time you reported this incident to your manager: 16-8-18 1pm

PART C – INCIDENT DETAILS

Where did the injury occur: ☑ as above ☐ other (specify)

Date of injury: 16-8-18 Time of injury: 1pm

Full Name: Matthew Walsh Contact No: 0423 143 306.

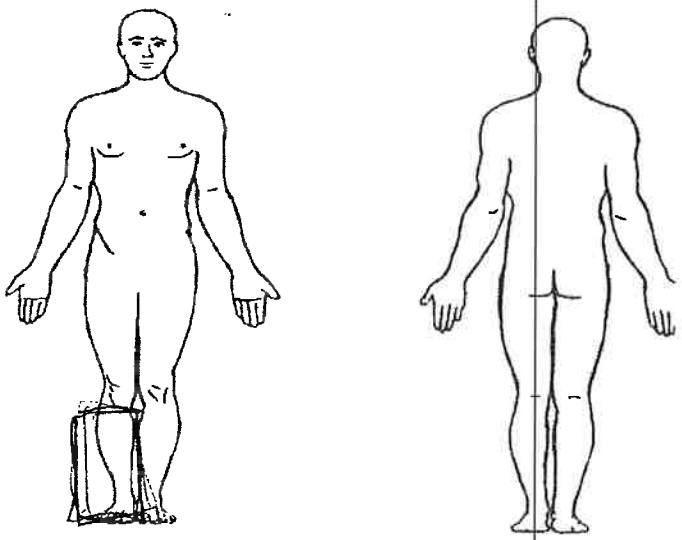
Was there any witnesses ☐ No ☑ Yes (specify): Denis Alveris. Contact No:

Contact No:

Is photo evidence attached: ☑ No ☐ Yes (specify)

What training was completed: ☐ None ☑ SOP ☐ Tool Box ☐ Site Induction ☑ AAG Induction ☐ Other (specify)

Please mark the location of where the injuries occurred. Please Take note of the left and right side of the body and add notes as required.



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PART D – INCIDENT TYPE - Please ensure all relevant categories are marked

☐ Amputation	☐ Electric shock	☐ Sound and pressure
☐ Serious lacerations	☐ Burn(s)	☐ Body Stressing
☐ Minor lacerations	☐ Manual Handling	☐ Bullying, Harassment
☐ Falls, Slips, Trips (from height)	☐ Hitting object with body part	☐ Mental Stress
☐ Falls, Slips, Trips (from same level)	☑ Hit by moving object	☐ Near Miss
☐ Fracture	☐ Chemical related	☐ Other

PART E – REMEDY - Please ensure all relevant categories are marked

☐ No First Aid Required	☑ Medical Treatment (Hospital)	☐ Fatality
☐ First Aid Required – No Doctor Required	☐ Medical Treatment (Medical Centre)	☐ N/A Near Miss

PART F – ADDITIONAL MATTERS - Please ensure all relevant categories are marked

☐ SWP was not followed	☐ Equipment was not sufficient	☐ N/A Near Miss
☐ There was improper supervision	☐ Equipment was damaged	☐ Other (please specify below)
☐ There was improper training	☐ Equipment was misused	

PART G – DESCRIPTION OF INCIDENT - Please ensure all relevant categories are marked

Working under vehicle and had lower body hanging out from under car & other Tech reversed up onto my right leg. (Ouch)

PART H – IMMEDIATE ACTION TAKEN

Visit hospital for examination & Xrays.

PART I - ACKNOWLEDGEMENT

Full Name	Position	Signature	Date
Matthew Walsh	Tech	MJ Walsh	20/08/18.
FRED JEANES	Service manager		29/8/18.

Certificate of capacity/ certificate of fitness

NSW GOVERNMENT

State Insurance Regulatory Authority

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

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: Matthew

Last name: Walsh

Date of birth (DD/MM/YYYY): 14.03.1994

Telephone number: 0423143306

Address (must be residential address - not PO Box): 16/21 View ST Miranda

Suburb: Miranda

State: NSW

Postcode: 2228

Claim number:

Medicare number:

Occupation/job title: mechanic

Employer's name and contact details (if applicable): City Ford Rockdale

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: M Walsh

Date (DD/MM/YYYY): 16.08.18.

Section 2: To be completed by treating medical practitioner

Medical certification

Diagnosis of work related injury/disease or motor accident related injury(ies): soft tissue injury.

Person's stated date of injury/accident (DD/MM/YYYY): 16.08.2018

Shaded areas to be completed for initial certificate only

Person was first seen at this practice/hospital for this injury on (DD/MM/YYYY): 16.08.18

Injury is consistent with person's description of cause: ☑ Yes ☐ No ☐ Uncertain

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

Another Car's rear wheel was reversed over his right lower leg.

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

ice / elevate / rest. paracetamol / ibuprofen.

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

GP

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

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 (DD/MM/YYYY) 20/08/2018 (if greater than 28 days, please provide clinical reasoning)

Comments

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

OR

☐ has capacity for some type of work from ____ to ____ for ____ hours/day ____ days/week

OR

☑ has no current capacity for any work from 16/08 to 20/08.

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

Factors affecting recovery

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)

Name: A. Hoole NP.

Address: TSH ED.

Suburb: Caringbah | State: NSW | Postcode

Telephone number | Provider number

☐ 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)

Catalogue No. SIRA08719
State Insurance Regulatory Authority, 92-100 Donnison Street, Gosford, NSW 2250
Locked Bag 2906, Lisarow, NSW 2252 | Customer Experience 13 10 50
Website www.sira.nsw.gov.au

NSW GOVERNMENT | State Insurance Regulatory Authority

Result type: Discharge Referral Note
Result date: 16 August 2018 20:23 AEST
Result status: Auth (Verified)
Result title: Discharge Referral ED
Verified by: Hodge, Alister (NP) on 16 August 2018 20:23 AEST
Visit Info: 1004175854, Sutherland, Emergency, 16/08/2018 -

Discharge Referral ED

Patient: **Walsh , Matthew** **MRN: 10636563** **FIN: 1004175854**
Age: **24 years** Sex: **Male** DOB: **14/03/1994**
Associated Diagnoses: **Soft tissue injury**
Author: **Hodge, Alister (NP)**

Visit Information

Facility:	The Sutherland Hospital	
Admission Date:	16/08/2018	To be discharged: 16/08/2018
Medical Service:	Emergency Medicine	Consulting Clinician:
Attending Medical Officer:		Finckh, Andrew
AMO Provider No.:	0133019F	Indigenous Status: Neither Aboriginal nor Torres Strait
Local Medical Officer:	Akhter, Shamima	
LMO Provider No.:	2572107H	
LMO Address:	573 The Kingsway , Miranda, 2228	
LMO Phone:	(02)9540 1044	LMO Fax: (02)9526 1343
Interpreter Required:	NO	Language spoken at home: English

Dear Dr Shamima Akhter,

Thank you for reviewing Matthew Walsh a 24 year old male to be discharged on 16/08/2018 from the Emergency D
TSH at The Sutherland Hospital and Community Health Service. The summary of their presentation and condition
documented below.

Summary of Care
pc: lower limb injury

hpc:
working as mechanic
while working on car with legs hanging out next to car, other person reversed another car
rear wheel went over toe of left foot, and then over right foot / tib / knee
ambulant post
no injury to pelvis / abdo / chest / spine
no wounds

allergies: nkda
meds: nil
pmhx: nil

OE:
alert, orientated, well perfused, nil resp distress

left foot: NAD. no bony tenderness
right foot: NAD
right ankle: no swelling / wounds. tender lat malleolus only
right knee: tender head of fibula only. full ROM. no laxity stressing of ligaments
no tenderness to midshaft / tib/fib

impression: soft tissue injury

investigation;
right tib fib xray: no clear fracture
right knee xray: no clear fracture
right ankle xray: no fracture. bone cyst noted in calcaneus on lateral view

plan: treat as soft tissue injury. paracetamol / ibuprofen for analgesia. follow up with GP for formal xray report

Health Status

Discharge and Other Diagnosis

Soft tissue injury (ED Medical).

Allergies and Adverse Reactions

No allergies have been recorded.

Results Review

Unresulted Diagnostic Tests for Follow-up

Order Date	Order Name
16/08/2018	Xray Ankle Right, Xray Leg & Knee Right

Pathology 1800 0 73257 | Radiology (02) 9540 7644 | Nuclear Medicine (02) 9113 3112

Discharge Information

Performed By

We are grateful for your management and continued care of this patient.

Kind Regards,

Alister Hodge (NP)
Emergency Dept TSH
Phone: 95407111

Discharge Plan

Changes to Medications Discharge Meds (from Powerform)

Medication information has not been updated for this patient, during this visit

Completed Action List:

* Perform by Hodge, Alister (NP) on 16 August 2018 20:23 AEST
* Sign by Hodge, Alister (NP) on 16 August 2018 20:23 AEST
* VERIFY by Hodge, Alister (NP) on 16 August 2018 20:23 AEST