Claimant name | Claim number

MANAGEMENT PLAN FOR THIS PERIOD

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

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? ☐ Yes ☐ No

Patient:

☐ is fit for pre-injury duties

☐ has capacity for some type of employment from ☐☐/☐☐/☐☐☐☐ to ☐☐/☐☐/☐☐☐☐

for ☐☐ hours/day ☐☐ days/week

☐ has no current work capacity for any employment from ☐☐/☐☐/☐☐☐☐ to ☐☐/☐☐/☐☐☐☐

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? ☐ 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 ☐☐/☐☐/☐☐☐☐ (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 or ☐ other* (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

Date (DD/MM/YYYY) ☐☐/☐☐/☐☐☐☐

*If 'other', please specify

Name (practice stamp if available)

Address

Telephone number

Provider number