

NORTHERN TERRITORY

Worker's Compensation Medical Certificate**PROGRESS CERTIFICATE****– Recommended maximum 28 days duration**

• Certificate to be given to worker • Doctor to retain a copy

NOTE: Maximum referral period for rehabilitation treatment prior to review is initially 14 days, and 28 days for subsequent referrals to the same discipline.

1. Worker Details		5. Injury Management (tick only those boxes which apply)	
Family Name:		Medical Practitioner / Employer Contact	
Given Name(s):		<input type="checkbox"/> I have made contact with the employer and discussed alternative work options OR <input type="checkbox"/> The worker will require more than three days off work, consequently I will be happy to discuss this further with the employer / insurer. * Please note my preferred contact times below	
Address:		Medical Management Plan	
Telephone:		<input type="checkbox"/> Medication: (please specify): <input type="checkbox"/> Physiotherapy / Chiropractor <input type="checkbox"/> Imaging <input type="checkbox"/> Other: (please specify) <input type="checkbox"/> Referred to specialist. Name: Specialty: <input type="checkbox"/> Referred to hospital (Name): <input type="checkbox"/> Surgery likely in the future Other comments:	
Date of injury or disease:	/ /	Vocational Rehabilitation	
Date of birth:	/ /	Options MUST be discussed with the Worker <input type="checkbox"/> Likely to be necessary, subject to review in ____ weeks <input type="checkbox"/> I would like the employer / insurer to organise a referral and discuss with me. * Please note my preferred contact times below	
2. Employer Details		6. Medical Practitioner Details	
Name of Worker's Employer:		Name:	
Employer's Address:		Registration No:	
3. Medical Assessment		Address:	
Time and date of examination:		*Preferred Contact Times	
Time: <input type="checkbox"/> am / <input type="checkbox"/> pm Date: / /		Days: Times:	
Clinical findings / diagnosis at this examination:		Telephone:	
4. Fitness for Work (tick only those boxes which apply)		Fax:	
Fit <input type="checkbox"/> Fit to return to pre-injury duties, no further treatment required <input type="checkbox"/> Fit to return to pre-injury duties, but requires further treatment <input type="checkbox"/> Fit to return to work for restricted hours / days from: ____ / ____ / ____ to ____ / ____ / ____ (inclusive) ____ hours per day ____ hours per week. <input type="checkbox"/> Fit to return to work on restricted duties from: ____ / ____ / ____ to ____ / ____ / ____ (inclusive) Restricted Duties <input type="checkbox"/> Avoid prolonged Standing / walking / sitting <input type="checkbox"/> Avoid squatting / kneeling / ladders / steps <input type="checkbox"/> No lifting anything heavier than <input type="checkbox"/> 5, <input type="checkbox"/> 10, <input type="checkbox"/> 15 or <input type="checkbox"/> 20 kg <input type="checkbox"/> Avoid repetitive use of affected body part <input type="checkbox"/> Avoid repetitive bending / lifting <input type="checkbox"/> Other restrictions: ____ <input type="checkbox"/> Duties recommended / capable: ____ Unfit <input type="checkbox"/> Totally unfit for work for ____ days from ____ / ____ / ____ to ____ / ____ / ____ (inclusive) <input type="checkbox"/> I will review the worker (date of next appointment) ____ / ____ / ____		Signature: Date: ____ / ____ / ____	