REDiMED TOTAL INJURY MANAGEMENT

WorkCover WESTERN AUSTRALIA

Workers' Compensation
PROGRESS Medical Certificate

Claim No.
(If Known)

1. Worker's Details

First name(s): Surname:
Address:
Telephone: Date of birth: Occupation:
Date of injury/disease, etc:

2. Time & Date of this Examination:

3. Employer Details

Name & address of worker's employer:

4. Progress Report (clinical findings/diagnosis at this consultation and possible barriers to return to work)

INJURY MANAGEMENT

5. Fitness For Work It is my opinion that as from the date of this certificate the worker is:

FIT

- ☐ Fit to return to pre-disability duties, no further treatment required.
- ☐ Fit to return to pre-disability duties, but requires further treatment.
- ☐ Fit for restricted return to work from: to
  - ☐ restricted hours (*please specify*):
  - ☐ restricted days (*please specify*):
  - ☐ restricted duties.
- ☐ Work restrictions:
- ☐ No lifting anything heavier than kg. Other restrictions:
  - ☐ Avoid repetitive bending / lifting.
  - ☐ Avoid repetitive use of affected body part.
  - ☐ Avoid prolonged standing / walking / sitting.
  - ☐ Keep injured area clean & dry.
  - ☐ Able to undertake duties agreed between doctor & employer.
  - ☐ UNFIT Totally unfit for work for days from to (*inclusive*).

6. Medical Management at this consultation

- ☐ Medication:
- ☐ Physiotherapy / Chiropractor *No. sessions recommended*: ☐ Imaging:
- ☐ Referred to hospital/specialist (*name*):

Other treatment:

Date of next appointment: **Time:**

7. Medical Practitioner / Employer Contact

- ☐ I have made contact with the employer and discussed alternative work options.
- ☐ The worker will be off work for more than **3 working days and/or is unable to return to normal duties. Employer please fax your contact details** as I will contact you to discuss return to work options.
- ☐ I have received contact details from the employer and I will contact the employer to discuss return to work options.
- ☐ The worker is able to return to normal duties. Contact with employer not necessary at this stage.

8. Return to Work Options

- ☐ Doctor and employer to coordinate return to work.
- ☐ Vocational rehabilitation not required.
- ☐ Vocational rehabilitation likely to be necessary, subject to review in weeks.
- ☐ Vocational rehabilitation assessment required – **choice of provider to be discussed with the worker**.
  - ☐ I have referred the worker to (*name of vocational rehabilitation provider*):
  - ☐ The worker has nominated (*name of vocational rehabilitation provider*):
  - Insurer please initiate referral.
  - ☐ I would like the employer / insurer to discuss with me organising referral.
- ☐ Vocational rehabilitation has been initiated and is continuing with:

Comments:

9. Medical Practitioner's Details

Name: Registration No.:
Address:
Telephone: Fax: Signature:

For workers' compensation information or assistance contact
WorkCover WA's Infoline: 08 9388 5555 Country callers: 1 800 670 055