**CLAIM ENQUIRIES**

Originalsignedcopy–Insurer|Secondcopy–Employer|Thirdcopy–Worker|Fourthcopy–Medical/DentalPractitioner



**WorkCover Queensland 1300 362 128**

**Self insurance or other enquiries 1300 361 235**

**Queensland**

**Workers’ compensation medical certificate**

**For general information about workers’**

**compensation visit www.qcomp.com.au**

**86.R**

VERSION  4

PARTS A AND E OF THIS MEDICAL CERTIFICATE COMPRISE AN APPROVED FORM

UNDER THE*WORKERS’ COMPENSATION AND REHABILITATION ACT 2003*

Tick      if applicable, and fill in the information as requested.

New claim

Claim number

**PART A - Worker’s details**

I certify that on / / I attended to (given names)

(surname) (DOB) / /

Worker’s daytime contact phone number

Worker’s employer name

The worker is/was suffering from (list all medical/dental diagnoses relevant to the claim):

Diagnosis:

This is a provisional diagnosis  (**if  provisional  complete  Part  B**)

Worker was first seen at this practice/hospital for this injury/disease on / /

Worker stated date of injury / /

Worker’s stated cause of injury (if not previously supplied):

Injury/disease is consistent with worker’s description of cause:     Yes    Uncertain

Detail any pre-existing factors or condition aggravated by the event (if not previously supplied):

**Worker’s capacity for work  (not  only  pre-injury  duties)**

**Please  consider  the*“health  benefits  of  work”*  when  certifying  the  worker’s  capacity**

To return to normal duties from / /

For suitable duties from / / to /     / (**complete Part D**)

No capability for any type of work / / to / / (**complete Part C**)

Estimated time to return to some form of work duties: days     weeks    unsure

**Medical management**

Worker will require treatment from    /     / to / / (**complete Part C**)

Worker will be reviewed again on / / No further review required

**PART B - Diagnostic plan**

I have ordered:    Diagnostic imaging    Pathology    Other investigations

**PART C - Medical management plan**

Treatment:

Medication prescribed:

Referred to specialist (specialty/name):

Referred to allied health professional (discipline/name):

Detail (specify):

I would like the insurer to arrange a case conference with (tick more than one if appropriate)

Treating practitioner     Treating Specialist       Treating Allied Health      Employer

Employer has been contacted

I would like the insurer to contact me

**Further information:**

**PART D - Rehabilitation and return to work plan**

Approval is given for a suitable duties program with the following guidelines

No   Occasional   Frequent                Comments

Lifting: weight limit     kg

Bending/twisting/squatting

Standing/sitting

Use of injured hand/arm

Pushing/pulling

Operating machinery /heavy vehicle

Driving a car

Keep wound clean and dry

Other considerations (specify):

Restricted hours/days (specify):

I require a suitable duties program to be provided to me for approval

**PART E - Medical/Dental practitioner details**  (please  print  clearly  or  use  practice  or  hospital  stamp)

Doctor’s name:                                          Practice/hospital name:

Postal address:

Preferred method of contact:     Ph:                                              day(s)/time(s)

Fax:                                 Email:

Signature:                                                                       Date:              /            /

Details:

Practice/hospital stamp here

This form was approved by the Chief Executive Officer of Q-COMP, the Workers’ Compensation Regulatory Authority, on 4   June   2012, pursuant to section

586 of the Workers’ Compensation and Rehabilitation Act 2003. PRIVACY STATEMENT – Under the Workers’ Compensation and Rehabilitation Act 2003

and earlier Queensland workers’ compensation legislation, the workers’ compensation insurer is authorised to collect the information on this form to process

the claimant’s application for compensation. Some or all of the information contained in this form may be disclosed to the claimant’s employer, another

insurer, medical or allied health providers or any other workers’ compensation authority in any jurisdiction.