Work capacity certificate – workers' compensation

Form 132M — Version 1

Workers' Compensation and Rehabilitation Act 2003

IMPORTANT INFORMATION : Work is an important part of recovery. In most cases an early return to work (or remaining at work) is beneficial for health and wellbeing. The treating practitioner's guidance increases the likelihood of positive return to work outcomes. A worker receiving continued support is three times more likely to regain their capacity to work. Consider the health benefits of work when certifying the patient's capacity.

Part A – Patient details

Name: Wendy Inafrenzi | Date of birth: 01/04/1974

Mobile number: 0 4 1 2 3 4 5 6 7 8 | Claim number: S24KT100345 | ☑ New claim ☐ Claim is report only

Occupation (if known): Psychiatric Nurse | Patient's employer: Dark Side of the Moon

Part B – Injury details

Date of examination: 19/02/2024 | Patient's stated date of injury: 25/12/2023 | Patient was first seen at this practice/hospital for this injury/disease on: 26/12/2023

The patient is/was suffering from *(List all work-related diagnoses. If symptoms only, tick "Provisional diagnosis")* ☐ Provisional diagnosis: R shouler SS repair and reattachment of labrum 05/01; whiplash injury 25/12

Patient's stated mechanism of injury: assault at work | Is this consistent with your clinical findings? ☑ Yes ☐ Unclear

Describe mechanism in detail: dementia patient grabbed and threw Ms Inafrenzi against furniture whilst she was dressing him

Pre-existing factors or condition aggravated *(if not previously supplied)*: Nil

Part C – Treatment plan

Patient requires/d treatment from: 19/02/2024 to: 01/04/2024 | to be reviewed again on: 29/03/2024 | No further review ☐

Treatment: Physio - mobility and functional strength;

I have prescribed medication that may impede safe work, travel or cognitive function ☐ No ☑ Yes

Referrals ☐ Diagnostic ☑ Allied Health ☐ Specialist/GP | Name/discipline: Physio, OT | Details *(specify)*: Physio - mobility strength; OT - FCE

Part D – Capacity for work *(Choose one from the three options)*

○ The certified injury does not prevent a return to pre-injury duties. **Do not complete Part E. Go to Part F.**

◉ If suitable duties available, can return to some form of work from: 19/02/2024 (DD/MM/YY)

○ No functional capacity for any type of work until:

Complete below section if you certified no functional capacity for any type of work

If no functional capacity, state why? *(if no capacity for more than 7 days, the insurer may contact you to obtain more information)*

Estimated time to return to some form of work duties:

Estimated time to return to full duties:

Part E – Functional ability *(Optional for emergency medical practitioners/dental practitioners. Nurse practitioners not to complete.)*

No change since last certificate ☐

Certification should be based on what CAN be done, NOT available duties. Consider what the patient can do, either at work or home.

Function/task *(patient's usual functional ability)*	Is functional ability affected by injury/condition? **No**	**Yes**	Note any restrictions *(if relevant)*	What patient can do *(if "Yes" box ticked)*
Lower limb	◉	○		
Upper limb	○	◉	no lifting, pulling, pushing with affected limb	
Hand function	○	◉	affected limb limited by sling	limited gripping with affected limb
Spinal function	○	◉	neck movement as tolerated only	
Cognition/psychosocial functioning	◉	○		
Driving a car	○	◉	no driving	ability to drive as directed by OT driving assessment
Operating machinery/heavy vehicle	○	○	NA	
Manual tasks	○	◉	(as above with affected limb)	
Other	○	◉		

Part F – Rehabilitation at work – return to work plan *(Optional for emergency medical practitioners/dental practitioners. Nurse practitioners not to complete.)*

What workplace modifications are required to facilitate return to work? *(e.g. work site assessment, psychosocial considerations)*

worksite assessment required for SDP

Other considerations or factors that may affect recovery *(the insurer can arrange appropriate support)*

Requires travel assistance for commute to work

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

I have discussed injury requirements and return to work options with the patient and ☑ Employer ☐ Insurer ☐ Rehabilitation provider

Part G – Medical/dental/nurse practitioner details and statement *(or use practice/hospital stamp)*

I have discussed the information contained in this certificate with the patient. I have provided the clinical information in this certificate.

Name: Dr Con Spikuous | Email: admin@efane-clinic.com

Practice/hospital: Eye For An Eye Work Injury Clinic | Phone: 0 7 9 9 8 8 1 1 1 1 | Date: 19/02/2024

Postal address: Brisbane Eye. Russell St, Southbank Parklands, South Brisbane QLD 4101 | Signature:

Further information www.worksafe.qld.gov.au/medicalsupport
All enquiries (medical/dental/nurse practitioner, patient, employer) 1300 362 128

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