

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		Date of birth	DD/MM/YYYY
Mobile number	Claim number	<input type="checkbox"/> New claim	<input type="checkbox"/> Claim is report only
Occupation (if known)	Patient's employer		

Part B – Injury details

Date of examination	DD/MM/YYYY	Patient's stated date of injury	DD/MM/YYYY	Patient was first seen at this practice/hospital for this injury/disease on	DD/MM/YYYY
The patient is/was suffering from (List all work-related diagnoses. If symptoms only, tick "Provisional diagnosis") <input type="checkbox"/> Provisional diagnosis					
Patient's stated mechanism of injury				Is this consistent with your clinical findings? <input type="checkbox"/> Yes <input type="checkbox"/> Unclear	
Describe mechanism in detail					
Pre-existing factors or condition aggravated (if not previously supplied)					

Part C – Treatment plan

Patient requires/d treatment from	DD/MM/YYYY	to	DD/MM/YYYY	to be reviewed again on	DD/MM/YYYY	No further review	<input type="checkbox"/>
Treatment							
I have prescribed medication that may impede safe work, travel or cognitive function <input type="checkbox"/> No <input type="checkbox"/> Yes							
Referrals	<input type="checkbox"/> Diagnostic <input type="checkbox"/> Allied Health <input type="checkbox"/> Specialist/GP	Name/discipline	Details (specify)				

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

<input type="checkbox"/> The certified injury does not prevent a return to pre-injury duties. Do not complete Part E. Go to Part F.	<input type="checkbox"/> If suitable duties available, can return to some form of work from	DD/MM/YYYY	<input type="checkbox"/> No functional capacity for any type of work until	DD/MM/YYYY
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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
	DD/MM/YYYY	DD/MM/YYYY

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?		What patient can do (if "Yes" box ticked)
	No	Yes	
Lower limb			
Upper limb			
Hand function			
Spinal function			
Cognition/psychosocial functioning			
Driving a car			
Operating machinery/heavy vehicle			
Manual tasks			
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)

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

 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		Email	
Practice/hospital		Phone	Date DD/MM/YYYY
Postal address		Signature	

Further information www.worksafe.qld.gov.au/medicalsupport

All enquiries (medical/dental/nurse practitioner, patient, employer) 1300 362 128