WorkCover QUEENSLAND

Orderly : Return to Work Checklist and Plan

Please complete with your patient

Worker name: _____ Claim number:_____ Injury: _____

Worker will be able to participate in the duties as below from: / / to / /

Full time ☐ Part time ☐ _____hours per day _____days/week

N.B. Based on your information, a suitable duties plan will be established at the worker's place of employment. In the absence of task availability at their usual workplace the worker will continue to be paid weekly compensation and WorkCover will source suitable alternative workplace rehabilitation with a host employer.

Please consider the “health benefits of good work” and focus on what your patient can do.

Tick if suitable	Job Tasks	Limitations/Comments
	General cleaning tasks - the worker may be required to clean trolleys, vacuum, empty bins, clean bathrooms, dusting. This includes left/right handed work, push/pulling actions, wiping basins/trolleys/benches, kneeling or squating, reaching etc.	
	Clean floors with a self-propelled/ride on floor scrubbing machine. This involves operating equipment.	
	Move fresh/soiled linen bags. This involves lfting and carrying the linen bags.	
	Push patients in wheelchairs from different areas of the hospital. The weight of this duty will depend on the patient and involves walking and a pushing motion.	(weight restriction)
	Moving patient on beds - assisting in the movement of patients for example rolling the patient on the bed to assist with dressings, chaging of linen etc.	
	Transfer patients - movement of patient on and off bed. Can be moving patient from bed to standing, from wheelchair to bed, from shower/toilet to chair etc	
Psychological restrictions		
	Liasing with colleagues & patients	
	Conflict management with patients, patients families & colleagues	
	Problem solving & negotiating in unexpected situations	
	Leadership and able to take direction in emergency situations	
	Ability to maintain concentration	
	Obtain new information and meet deadlines	
	Dealing with distressed/unpredicatable people	
Hours of work		
	Morning shift: YES / NO	Hours:
	Afternoon shift: YES / NO	Hours:
	Night shift: YES / NO	Hours:

Worker name: _____ Claim number:_____ Injury: _____

If none of the above tasks or alternate duties are appropriate at this time, please advise a review date or timeframe to some form of return to work _____ / _____ / _____

☐ Please tick here if you have been unable to identify any tasks and you would prefer an allied health provider to help implement a return to work plan.

Other comments:

_____

_____

_____

SIGNATURES

Treating Medical Practitioner: _____ / _____ / _____

Worker: _____ / _____ / _____

Employer: _____ / _____ / _____

Submission and payment for this form (WorkCover Queensland claims only)

If this form is requested as part of a workers' compensation claim, please forward this completed form via our online services, or alternatively by faxing to 1300 651 387. You can charge for a "completed form" under the relevant table of costs, found on our website worksafe.qld.gov.au. This form will become part of a claim file and may therefore be read by claims staff, WorkCover Queensland's network of advisory doctors, specialists at the Medical Assessment Tribunal or during legal proceedings.

In addition, the form that you provide may be released to another person (usually the worker or employer) under the Right to Information Act (2009), the workers' compensation legislation or as authorised or required by law.