

Workers' compensation medical certificate

CLAIM ENQUIRIES

WorkCover Queensland

1300 362 128

Self insurance or other enquiries 1300 361 235

86.R

PARTS A AND F 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 On-going claim Claim number: _____

PART A

Injured worker details

I certify that on ____/____/____ I attended (given names) _____
(surname) _____ (DOB) ____/____/____

Workers daytime contact phone number _____

Worker's employer name _____

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

Diagnosis: _____

This is a provisional diagnosis (if provisional complete Part C)

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

Pre-existing factors relevant to the diagnosis (if not previously supplied): _____

Worker's capacity for work

Fit to return to normal duties from ____/____/____

Fit for suitable duties (restricted return to work) from ____/____/____ to ____/____/____
(complete Part E)

Not able to work at all from ____/____/____ to ____/____/____
(complete Part D)

Estimated time to return to normal work duties: ____ days/weeks/months Unknown

(if greater than 10 days or unknown complete Part D)

Medical management

Worker will require treatment from ____/____/____ to ____/____/____ (complete Part D)

Worker will be reviewed again on ____/____/____

Worker does not need further review

PART B

Further information

Details of findings/clinical notes relevant to the condition: _____

I would like the insurer to contact me upon receipt of this certificate

Preferred method of contact:

Phone: day(s)/time(s) _____ Fax Email

This form was approved by the Chief Executive Officer of Q-COMP, the Workers' Compensation Regulatory Authority, on 23 January 2009, 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.

PART C

Diagnostic plan (complete if provisional diagnosis indicated at Part A)

I have ordered: Diagnostic imaging Pathology Other investigations

Details: _____

PART D

Medical management plan (complete if return to normal duties is estimated to be greater than 10 days)

Treatment: _____

Medication prescribed: _____

Referred to specialist (specialty/name): _____

Referred to allied health professional (discipline/name): _____

Other (specify): _____

PART E

Rehabilitation and return to work plan

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

	No	Occasional	Frequent	Comments
Lifting: weight limit ____ kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bending/twisting/squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Standing/sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Right/left-handed work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Driving or operating machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pushing/pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Keep wound clean and dry

Other considerations (specify): _____

Restricted hours (specify): _____

Restricted days (specify): _____

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

Contact has been made with the employer

I wish to be involved in the rehabilitation process

PART F

Medical/Dental Practitioner Details (please print clearly or use practice or hospital stamp)

Doctor's name: _____ Practice/hospital name: _____

Postal address: _____

Ph: _____ Fax: _____ Email: _____

Signature: _____ Date: ____/____/____

Practice/hospital Stamp Here

For general information about workers' compensation visit www.qcomp.com.au

VERSION 3

Original signed copy - Insurer | Second copy - Employer | Third copy - Worker | Fourth copy - Medical/Dental Practitioner

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Postal address: _____

Ph: _____ Fax: _____ Email: _____

Signature: _____ Date: ____/____/____

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