Work capacity certificate – workers' compensation

Workers' Compensation and Rehabilitation Act 2003

Form 132M — Version 1

WorkCover Hub

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

Mobile number

Claim number

☐ New claim ☐ Claim is report only

Occupation (if known) Select one

Patient's employer

Part B – Injury details

Date of examination

Patient's stated date of injury

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

The patient is/was suffering from *(List all work-related diagnoses. If symptoms only, tick "Provisional diagnosis")* ☐ Provisional diagnosis

Patient's stated mechanism of injury

Is this consistent with your clinical findings? ☐ Yes ☐ Unclear

Describe mechanism in detail

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

Part C – Treatment plan

Patient requires/d treatment from to to be reviewed again on No further review ☐

Treatment

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

Referrals ☐ Diagnostic ☐ Allied Health ☐ Specialist/GP Name/discipline

Details *(specify)*

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 DD/MM/YYYY

☐ 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	☐	☐		
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

Postal address

Signature

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

Under the *Workers' Compensation and Rehabilitation Act 2003* (the Act), the workers' compensation insurer is authorised to collect the information on this form to process the claimant's application for compensation. 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. The claimant may be contacted by the insurer, and the insurer may contact the claimant's employer and any other medical, allied health or rehabilitation provider about the injury. This form was approved by the Workers' Compensation Regulator on 31 May 2016, pursuant to section 586 of the Act.

Queensland Government

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