How to use the Work Capacity Certificate

Version 2 — Effective 1 July 2017

South Australian Return to Work scheme

Promote function by prescribing an active recovery

Prescribe capacity to achieve better recovery and return to work outcomes

www.rtwsa.com
13 18 55

Government of South Australia

Completing a Work Capacity Certificate

Using your patient's words, record the cause of their injury/ condition.

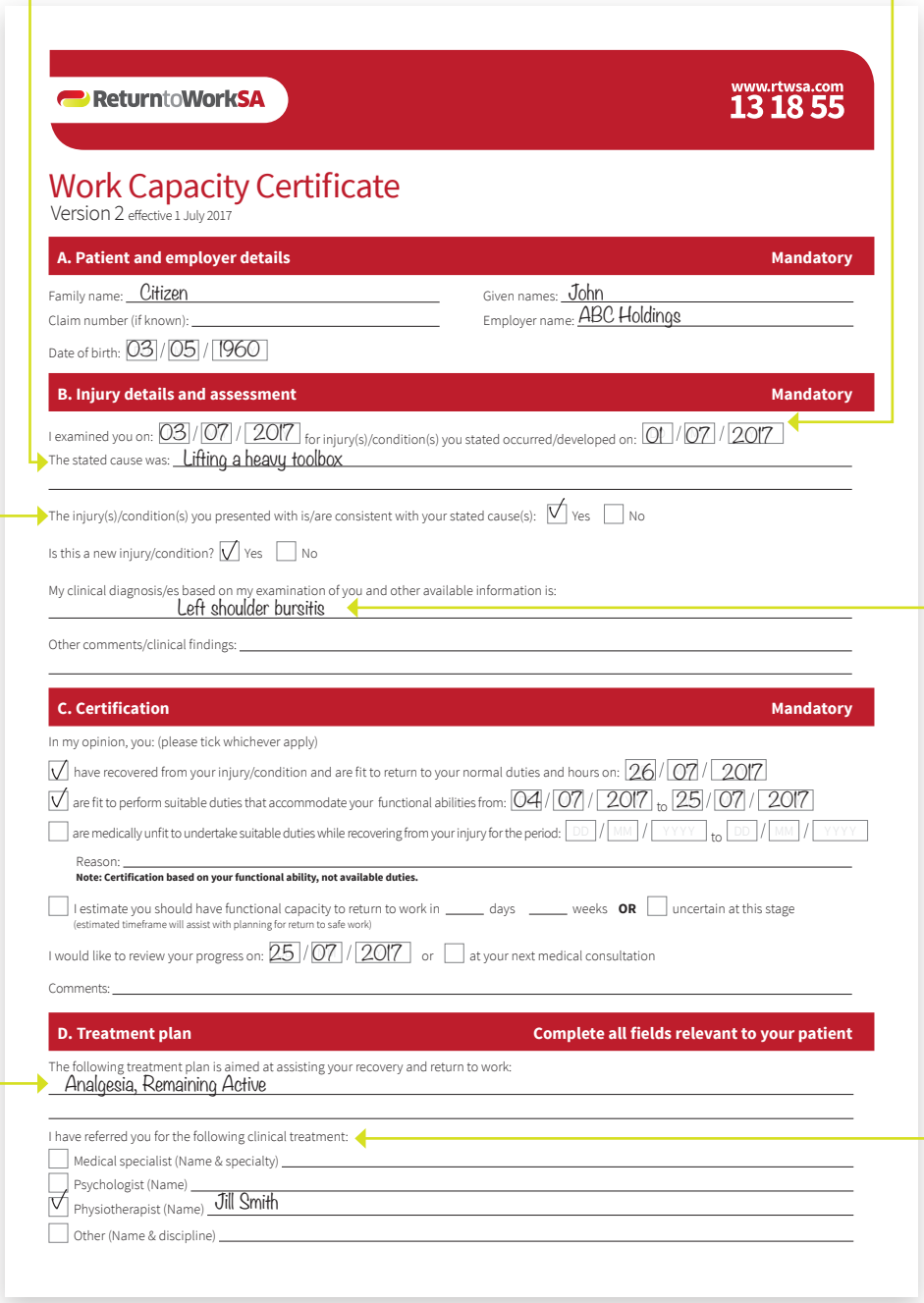
Record your opinion on whether it is reasonable to conclude that the symptoms your patient is presenting with could reasonably have resulted from their stated cause.

Outlining a treatment plan will help your patient have a clear understanding of what's required to help their recovery. It also helps their employer, case manager and other treating practitioners to plan and manage treatment and other support services for your patient.

Record the date your patient says their injury/condition occurred/ commenced.

Recording a clear clinical diagnosis is important for influencing your patient's and their case manager's perception about the severity of the condition, and expectations about recovery timeframes. For psychological injuries, a DSMIV diagnosis is preferable.

Indicating whether a referral has been made and to whom helps other treating practitioners and the case manager know who's in your patient's treating team, and assists communication.



ReturntoWorkSA

www.rtwsa.com
13 18 55

Work Capacity Certificate

Version 2 effective 1 July 2017

A. Patient and employer details **Mandatory**

Family name: Citizen
Given names: John
Claim number (if known):
Employer name: ABC Holdings
Date of birth: 03 / 05 / 1960

B. Injury details and assessment **Mandatory**

I examined you on: 03 / 07 / 2017 for injury(s)/condition(s) you stated occurred/developed on: 01 / 07 / 2017
The stated cause was: Lifting a heavy toolbox

The injury(s)/condition(s) you presented with is/are consistent with your stated cause(s): ☑ Yes ☐ No

Is this a new injury/condition? ☑ Yes ☐ No

My clinical diagnosis/es based on my examination of you and other available information is:
Left shoulder bursitis

Other comments/clinical findings:

C. Certification **Mandatory**

In my opinion, you: (please tick whichever apply)

☑ have recovered from your injury/condition and are fit to return to your normal duties and hours on: 26 / 07 / 2017
☑ are fit to perform suitable duties that accommodate your functional abilities from: 04 / 07 / 2017 to 25 / 07 / 2017
☐ are medically unfit to undertake suitable duties while recovering from your injury for the period: DD / MM / YYYY to DD / MM / YYYY

Reason:
Note: Certification based on your functional ability, not available duties.

☐ I estimate you should have functional capacity to return to work in ____ days ____ weeks **OR** ☐ uncertain at this stage
(estimated timeframe will assist with planning for return to safe work)

I would like to review your progress on: 25 / 07 / 2017 or ☐ at your next medical consultation

Comments:

D. Treatment plan **Complete all fields relevant to your patient**

The following treatment plan is aimed at assisting your recovery and return to work:
Analgesia, Remaining Active

I have referred you for the following clinical treatment:
☐ Medical specialist (Name & specialty)
☐ Psychologist (Name)
☑ Physiotherapist (Name) Jill Smith
☐ Other (Name & discipline)

Aim to document the activities your patient can do safely at home, at work and during leisure activities.

Think about what they can do, irrespective of whether suitable duties currently exist at their employer. It is the role of your patient's employer to accommodate your patient's level of function within the workplace. They, and your patient's case manager, will use the information you provide here to identify suitable work activities your patient could do while recovering.

Restrictions apply to home, leisure and employment activities.

Ticking this box indicates there are no restrictions on your patient's abilities to perform domestic, leisure and work activities as a result of this work injury/condition.

E. Functional ability — Complete all fields relevant to your patient

Your ability to work is affected by **this** injury(s)/condition(s) as follows:
(please select applicable functions – blank fields indicate that limitations don't apply. Please include any impact of medications on function)

☐ No restrictions - go to section G (Doctor's details)

Physical function	Can	With modifications	Cannot
Sitting:	☑	☐	☐
Standing/walking:	☑	☐	☐
Kneeling/squatting:	☑	☐	☐
Carrying/holding/lifting:	☐	☑	☐
Reaching above shoulder:	☐	☑	☐
Bending:	☑	☐	☐
Use of affected body part:	☐	☑	☐
Neck movement:	☑	☐	☐
Climbing steps/stairs/ladders:	☐	☑	☐
Driving:	☐	☑	☐

Comments (e.g. details of capacity or limitations that will assist in identification of suitable duties)

Limit left arm lifting to 5kg

Avoid: Heaving pulling, pushing, extended forearm reaching

Avoid overhead reaching

Driving as tolerated

Mental health function	Not affected	Partially affected	Affected
Attention/concentration:	☑	☐	☐
Memory (short term and/or long term):	☑	☐	☐
Judgement (ability to make decisions):	☑	☐	☐

☐ **Other functional considerations** - not listed above

☐ I have prescribed medication(s) that could impact upon your ability to undertake some activities.
Details: _____

I recommend:

☑ A graduated increase in working hours over 3 weeks from 5 hours a day to your normal hours/ ~~hours a day~~

☐ Non-consecutive working days for a period of _____ days or _____ weeks

F. Communication — Optional

Preferred contact method: ☐ phone ☐ email ☐ fax ☐ writing ☑ visit

G. Doctor's details — Mandatory

Doctor's name: DR Peter Jones
Address: 10 ABC St
Adelaide SA 5000
Phone: (08) 1234 5678

Provider Number: 023456Y
Email address: pjones@xy3.com.au
Fax: (08) 1234 5679
Signed: P Jones
Completion date: 03 / 07 / 2017

RTWSA-PC-0822.4/9/2017

Indicating the potential side effects of prescribed medication helps your patient's employer identify safe work activities for them during their recovery. i.e. avoid operating machinery.

It also alerts your patient to home or leisure activities they should avoid.

The completion date must be the day on which the certificate was written. Certificates can not legally be backdated.

If you have previously seen your patient for this injury/ condition and not completed a Work Capacity Certificate, please make note of this, including the date, within the comments section.

Prescribing a graduated increase in activity over a specified timeline can be a practical way of encouraging an active recovery and building activity as your patient's function improves during the recovery period.

ReturntoWorkSA

www.rtwsa.com
13 18 55

Prescribing capacity: *a guide for medical practitioners*

Use the flow chart below to help you complete section C of the Work Capacity Certificate.

Is your patient fit to return to their entire pre-injury role?

YES

C. Certification **Mandatory**

In my opinion, you: (please tick whichever apply)

☑ have recovered from your injury/condition and are fit to return to your normal duties and hours on: 26 / 07 / 2017

☐ are fit to perform suitable duties that accommodate your functional abilities from: DD / MM / YYYY to DD / MM / YYYY

☐ are medically unfit to undertake suitable duties while recovering from your injury for the period: DD / MM / YYYY to DD / MM / YYYY

Reason: _____

Note: Certification based on your functional ability, not available duties.

☐ I estimate you should have functional capacity to return to work in _____ days _____ weeks **OR** ☐ uncertain at this stage
(estimated timeframe will assist with planning for return to safe work)

I would like to review your progress on: 25 / 07 / 2017 or ☐ at your next medical consultation

Comments: _____

NO

Does your patient have sufficient function to safely participate in *some* work activities?

i.e. if their level of function was accommodated through modifications to their:

- Role/ activities
- Workstation
- Pace or intensity of role/ activities
- Hours worked/ overtime

YES

C. Certification **Mandatory**

In my opinion, you: (please tick whichever apply)

☐ have recovered from your injury/condition and are fit to return to your normal duties and hours on: DD / MM / YYYY

☑ are fit to perform suitable duties that accommodate your functional abilities from: 04 / 07 / 2017 to 04 / 07 / 2017

☐ are medically unfit to undertake suitable duties while recovering from your injury for the period: DD / MM / YYYY to DD / MM / YYYY

Reason: _____

Note: Certification based on your functional ability, not available duties.

☐ I estimate you should have functional capacity to return to work in _____ days _____ weeks **OR** ☐ uncertain at this stage
(estimated timeframe will assist with planning for return to safe work)

I would like to review your progress on: 25 / 07 / 2017 or ☐ at your next medical consultation

Comments: _____

NO

NO

Does your patient have insufficient function to undertake any form of work while they are recovering from their injury?

i.e. no workplace modifications will make it safe for them to participate in work, and it is quite difficult for them to perform most home, leisure and work activities.

Given the negative health impact of being absent from the workplace, please certify for short periods only, with an early review date.

YES

C. Certification **Mandatory**

In my opinion, you: (please tick whichever apply)

☐ have recovered from your injury/condition and are fit to return to your normal duties and hours on: DD / MM / YYYY

☐ are fit to perform suitable duties that accommodate your functional abilities from: DD / MM / YYYY to DD / MM / YYYY

☑ are medically unfit to undertake suitable duties while recovering from your injury for the period: 04 / 07 / 2017 to 11 / 07 / 2017

Reason: _____

Note: Certification based on your functional ability, not available duties.

☐ I estimate you should have functional capacity to return to work in _____ days _____ weeks **OR** ☐ uncertain at this stage
(estimated timeframe will assist with planning for return to safe work)

I would like to review your progress on: 11 / 07 / 2017 or ☐ at your next medical consultation

Comments: _____

For more information

www.rtwsa.com
info@rtwsa.com
13 18 55
8:30am–5:00pm Monday to Friday

For Braille, audio or e-text call 13 18 55.

If you are deaf or have a hearing or speech impairment you can call ReturnToWorkSA through the National Relay Service (NRS):

- **TTY users** can phone 13 36 77 and ask for 13 18 55
- **Speak & Listen (speech-to-speech) users** can phone 1300 555 727 and ask for 13 18 55
- **Internet Relay users** connect to NRS on www.relayservice.com and ask for 13 18 55.

For languages other than English call the Interpreting and Translating Centre on 1800 280 203 and ask for an interpreter to call ReturnToWorkSA on 13 18 55.

RTWSA.FYC.1674.v2.27.6.2016