Workers' Compensation
PROGRESS Medical Certificate

1. Worker's Details **Claim No. PE2201399**

First Name(s): **Raymond** Surname: **MORRISON**
Address: **40 Toledo Circuit PORT KENNEDY WA 6172**
Telephone: Date of Birth: **19/08/1985** Occupation:

Date of Injury/Disease first noticed **24/02/22** **2. Time and Date of this Examination:** **9:02 AM** **05/04/2022**

3. Employer Details
Name of Worker's Employer: **QBE**
Employer's Address:

4. Progress Report
Clinical findings/diagnosis (include possible complications, effect of prior injury or medical condition):

HISTORY: work injury when twisting 24/2 EXAMINATION: xray INVESTIGATIONS: xray, US, CT, MRI DIAGNOSIS: lateral ligament and syndesmosis injury

In my opinion the above diagnosis does correlate with the injury/disease etc. as described to me by the worker

INJURY MANAGEMENT

5. Fitness for Work It is my opinion that as of the date of this certificate the worker is

- ☐ Fit to return to pre-disability duties 00/00/0000
- ☐ Requires further treatment.
- ☐ Fit for restricted return to work from: 00/00/0000
  Restricted hours 00/00/0000 to 00/00/0000 hrs per day
  Restricted days days per week
- ☐ Fit to return to modifed/other duties from 00/00/0000 to 00/00/0000
  - ☐ Avoid Prolonged Standing
  - ☐ Avoid Prolonged Walking
  - ☐ Avoid Prolonged Sitting
  - ☐ Avoid Squatting
  - ☐ Avoid Kneeling
  - ☐ Avoid Ladders
  - ☐ Steps Restriction
  - ☐ Avoid Lifting Over kg
  - ☐ Avoid Elevating arms
  - ☐ Avoid repetitive use of affected part
  - ☐ Avoid repetitive bending
  - ☐ Avoid repetitive lifting
- ☒ UNFIT - Totally unfit for work from 05/04/2022 to 10/05/2022

6. Medical Management (at this consultation)

Medication:

- ☐ Specialist Referral Specialty: Name: Date: **00/00/0000** Time: **12:00 AM**
- ☐ Hospital Referral
- ☐ Allied Health Referral Specialty: Name:
- ☐ Requires Special Assistance

Other Treatment: Cam boot next 5 weeks, physiotherapy

Next Appointment **(Unless "First & Final Certificate")** **11/05/2022**

7. Medical Practitioner/Employer Contact

- ☐ I have made contact with the employer and discussed alternative work options.
- ☒ The worker will be off work for more than 3 working days and/or is unable to return to normal duties. Employer please fax your contact details as I will contact you to discuss return to work options.
- ☐ I have received contact details from the employer and I will contact the employer to discuss return to work options.
- ☐ The worker is able to return to normal duties. Contact with employer not necessary at this stage.

8. Return to Work Options

- ☐ Doctor and employer to coordinate return to work
- ☒ Vocational rehabilitation not required
- ☐ Vocational rehabilitation likely to be necessary, subject to review in weeks
  - ☐ I have referred the worker to (name of VR provider)
  - ☐ The worker has nominated (name of VR provider)
  - ☐ I would like the employer/insurer to discuss with me organising referral
- ☐ Vocational rehabilitation has been initiated and is continuing with

Comments: ftouch wt bearing another week, then PWB 2 weeks, then WBAt and wean off boot over 2 weeks

10. Medical Practitioner Details

Name: **Mr Doug Kingwell** Registration No: **MED0001535788**
Address: **31 Outram Street**
WEST PERTH WA 6005
Telephone: **08 9212 4200** Fax: **08 9212 4264** Signature.....