WorkCoverWA

Form 4A

WorkCover WA - PROGRESS certificate of capacity

1. WORKER'S DETAILS

First name	Raymond	Last name	MORRISON
Date of birth	19/08/1985	Claim no.	PE2201399
Phone		Email	ray.morrison85@hotmail.com
Address	40 Toledo Circuit, PORT KENNEDY, WA, 6172		

2. EMPLOYER'S DETAILS

Employer's name	QBE	Employer's phone	
Employer's address	, , , ,		

3. MEDICAL ASSESSMENT

Date of this assessment	20/10/2022	Date of injury	24/02/2022
Diagnosis	lateral ligament and syndesmosis injury, CRPS		

4. PROGRESS REPORT

Activities/interventions	Actual outcome *(change in symptoms, function, activity and work participation)*	Still required?*	
physio		☑ Yes	☐ No
pain clinic review		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No

**(If management activities/interventions are still required, please also list them in Section 6 'Injury Management Plan')*

☐ Other factors appear to be impacting recovery and return to work

Comment: improving somewhat but not ready for work

5. WORK CAPACITY

Worker's usual duties: driving

Having considered the health benefits of work, I find this worker to have:

☐ **full capacity for work** from _____ ☐ but requires further treatment

☐ **some capacity for work**, from _____ to _____ performing:

- ☐ pre-injury duties
- ☐ modified or alternative duties
- ☐ workplace modifications
- ☐ pre-injury hours
- ☐ modified hours of _____ hrs/day _____ days/wk

☑ **no capacity for any work** from 20/10/2022 to 18/01/2023 *(outline clinical reason on next page)*

5. WORK CAPACITY (CONTINUED)

Worker has capacity to:

(Please outline the worker's physical and/or psychosocial capacity – refer to explanatory notes for examples. Where there is no capacity for work, please provide clinical reasoning.)

- ☐ lift up to ____ kg
- ☐ sit up to ____ mins
- ☐ stand up to ____ mins
- ☐ walk up to ____ m
- ☐ work below shoulder height

6. INJURY MANAGEMENT PLAN

Activities/interventions	Purpose/goal *(likely change in symptoms, function, activity and work participation)*
physio, pain review, wean off	

- ☐ I support the RTW program established by the employer/insurer/WRP dated
- ☐ I would like more information about available duties
- ☐ I would like to be involved in developing the RTW program
- ☐ Please engage a workplace rehabilitation provider *(If you have made a referral, provide name and contact details below)*

Examples of injury management activities/interventions include:

- *further assessment - diagnostic imaging, medical specialist consults, worksite assessment*
- *intervention - physiotherapy, clinical psychology, exercise physiology, prescribed medications, workplace mediation*
- *return to work planning - identify suitable duties, establish return to work program*

7. NEXT REVIEW DATE

☑ I will review worker again on 18/01/2023 *(If greater than 28 days, please provide clinical reasoning)*

Comments

8. MEDICAL PRACTITIONER'S DETAILS

Name: Mr Doug Kingwell

Address: 31 Outram Street
WEST PERTH WA 6005

Phone: 08 9212 4200

Fax: 08 9212 4264

(Practice stamp – optional)

AHPRA no. MED: MED0001535788

Email:

Signature:

Date: 20 Oct 2022