ReturntoWorkSA

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Work Capacity Certificate

Version 2 effective 1 July 2017

A. Patient and employer details — Mandatory

Family name: Young
Given names: Hayley
Claim number (if known):
Employer name: BUNNINGS
Date of birth: 14/01/2002

B. Injury details and assessment — Mandatory

I examined you on: 27/07/2024 for injury(s)/condition(s) you stated occurred/developed on: 02/07/2024

The stated cause was: repetitive lifting

The injury(s)/condition(s) you presented with is/are consistent with your stated cause(s): [X] Yes [ ] No

Is this a new injury/condition? [X] Yes [ ] No

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

RIGHT SUBACROM 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 work to your normal duties and hours on:
- ☑ are fit to perform suitable duties that accommodate your functional abilities from: 27/07/2024 to 10/08/2024
- ☐ are medically unfit to undertake suitable duties while recovering from your injury period: to

Reason: SEVERE SHOULDER PAIN

Note: Certification based on functional capacity, 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: 10/08/2024 ☐ **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:

I have referred you for the following clinical treatment :

- ☐ Medical specialist (Name & specialty)
- ☐ Psychologist (Name)
- ☑ Physiotherapist (Name) PHYSIO 4 LIFE ELIZABETH
- ☐ Other (Name & discipline)

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 functions)

☐ No restrictions - got 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)

no lifting right arm above 3kg
work between shoulder and waist height
no repetitive use right upper limb

FOR CORTISONE INJECTION RIGHT SHOULDER

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 ____ weeks from ____ hours a day to your normal hours/ ____ hour 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 Trang Luu

Address: 14 Anderson Walk Smithfield SA 5114

Phone: 8254 7700

Provider Number: 213187ET

Email Address:

Fax: 8254 7900

Signed:

Completion date: 27/07/2024

Sensitive: Medical (when complete)