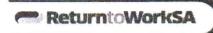
Mandatory



Work Capacity Certificate

Version 2 effective 1 July 2017

A. Patient and employer details		Mandatory	
Family name: Young Claim number (if known): Date of birth: 14/01/2002	Given names: Hayley Employer name: BUNNINGS		
B. Injury details and assessmen	ıt.	Mandatory	
l 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 or	n:	
are fit to perform suitable duties that accor	mmodate your functional abilities from: 27/07/2024	to 10/08/2024	
☐ are medically unfit to undertake suitable de	uties while recovering from your injury period:	to	
Reason: SEVERE SHOULDER PAIN			
Note: Certification based on functional capacity, no			
l estimate you should have functional capa		uncertain at this stage	
(estimated timeframe will assist with planni I would like to review your progress on:			
would like to review your progress on: 10/08/2024 □ OR at your next medical consultation			
D. Treatment plan	Complete all fields releva	ant to your nationt	
The following treatment plan is aimed at assisting your recovery and return to work:			
g and return to work:			
have referred you for the following clinical treatment :			
☐ Medical specialist (Name & specialty)			
☐ Psychologist (Name)			
☑ Physiotherapist (Name)	PHYSIO 4 LIFE ELIZABETH		
Other (Name & discipling)			

Sitting: Standing/walking: Kneeling/squatting: Carrying/holding/lifting: Descripting above shoulder: modifications identification of suitable during identification of sui	g vaist height
Physical function: Can With modifications Sitting: Standing/walking: Kneeling/squatting: Carrying/holding/lifting: Pagebing above shoulder: Can With modification of suitable during tight arm above 3kg work between shoulder and work between shoul	g vaist height
Standing/walking: Kneeling/squatting: Carrying/holding/lifting: Descripting above shoulder: In no lifting right arm above 3kg work between shoulder and work between shoul	vaist height
Bending: Use of affected body part: Neck Movement: Climbing steps/stairs/ladders: Driving:	ON 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 Non-consecutive working days for a period of Weeks from hours a day to your normal 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:	Mandatory

E. Functional ability

Complete all fields relevant to your patient

Sensitive: Medical (when complete)

Completion date: 27/07/2024