SECTION D Additional information for absences known/expected to exceed two weeks (please print)

Describe the patient's condition in terms of symptomology (severity and frequency), objective findings and impact on activities of daily living.

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other _____ | Patient's height: _____ Patient's weight: _____

Is complete recovery expected? ☐ **No** ☐ **Yes**

Please describe any factors that may affect this patient's ability to return to work.

Please attach copies of all relevant test results/investigations and consultation reports (if test results are not attached, it will be assumed that tests were not performed). If a consultation report is not attached please indicate if your patient has or will be seen by a specialist for this condition.

Name of specialist: _____ Specialty: _____ Date of Visit: _____

Name of specialist: _____ Specialty: _____ Date of Visit: _____

Please list any complications and additional condition(s) impacting your patient's level of function or the expected recovery period.

Physical impairment

Does your patient have a physical impairment?

☐ **No** ☐ **Yes**

If yes, please complete this section.

Based on your assessment please describe your patient's current abilities in the following areas:

Lifting (max. weight/frequency)		Standing (duration/frequency)	
Carrying (max. weight/distance)		Walking (distance/frequency)	
Pushing/Pulling (max. weight/frequency)		Climbing (duration/frequency)	
Walking on uneven ground (distance/frequency)		Crawling (duration/frequency)	
Working at heights (distance/frequency)		Keying/Typing (duration/frequency)	
Sitting (duration/frequency)		Mousing (duration/frequency)	

Remarks:

Cognitive/Mental impairment

Does your patient have a cognitive/mental limitation?

☐ **No** ☐ **Yes**

If yes, please complete this section.

Indicate if patient currently has cognitive/mental restrictions in the following areas:

	None	Mild	Moderate	Severe
Concentration (e.g. attention, orientation)				
Analytical reasoning (e.g. judgment)				
Learning new material (e.g. memory)				
Comprehension				
Social interaction (e.g. mood)				
Ability to multi-task				

In your opinion, is your patient competent to manage his/her own affairs? ☐ **No** ☐ **Yes**

Remarks:

Rehabilitation / Work re-entry

Has your patient expressed any concerns related to return to work? ☐ **No** ☐ **Yes,** Please describe:

Expected date of return to work to full duties (dd/mm/yyyy):

Please provide details about return-to-work plans for the patient:

To your knowledge is the patient following the recommended treatment program? ☐ **No** ☐ **Yes**

Has your patient's professional licence certification, driver's or other licence been restricted, suspended or revoked? ☐ **No** ☐ **Yes**

Signature:	Title/Profession:	Date signed (dd/mm/yyyy):