CLAIM ENQUIRIES
WorkCover Queensland 1300 362 128
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VERSION 4

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Tick ☑ if applicable, and fill in the information as requested.

☐ New claim

Claim number

PART A - Worker's details

I certify that on ___/___/___ I attended to (given names) _____

(surname) _____ (DOB) ___/___/___

Worker's daytime contact phone number _____

Worker's employer name _____

The worker is/was suffering from (list all medical/dental diagnoses relevant to the claim):

Diagnosis: _____

☐ This is a provisional diagnosis (**if provisional complete Part B**)

Worker was first seen at this practice/hospital for this injury/disease on ___/___/___

Worker stated date of injury ___/___/___

Worker's stated cause of injury (if not previously supplied): _____

_____

Injury/disease is consistent with worker's description of cause: ☐ Yes ☐ Uncertain

Detail any pre-existing factors or condition aggravated by the event (if not previously supplied):

_____

Worker's capacity for work (not only pre-injury duties)

Please consider the *"health benefits of work"* when certifying the worker's capacity

☐ To return to normal duties from ___/___/___

☐ For suitable duties from ___/___/___ to ___/___/___ (**complete Part D**)

☐ No capability for any type of work ___/___/___ to ___/___/___ (**complete Part C**)

Estimated time to return to some form of work duties: _____ ☐ days ☐ weeks ☐ unsure

Medical management

☐ Worker will require treatment from ___/___/___ to ___/___/___ (**complete Part C**)

☐ Worker will be reviewed again on ___/___/___ ☐ No further review required

PART B - Diagnostic plan

I have ordered: ☐ Diagnostic imaging ☐ Pathology ☐ Other investigations

Details: _____

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PART C - Medical management plan

Treatment: _____

Medication prescribed: _____

Referred to specialist (specialty/name): _____

Referred to allied health professional (discipline/name): _____

Detail (specify): _____

I would like the insurer to arrange a case conference with (tick more than one if appropriate)

☐ Treating practitioner ☐ Treating Specialist ☐ Treating Allied Health ☐ Employer

☐ Employer has been contacted

☐ I would like the insurer to contact me

Further information: _____

_____

PART D - Rehabilitation and return to work plan

☐ Approval is given for a suitable duties program with the following guidelines

	No	Occasional	Frequent	Comments
Lifting: weight limit ___ kg	☐	☐	☐	_____
Bending/twisting/squatting	☐	☐	☐	_____
Standing/sitting	☐	☐	☐	_____
Use of injured hand/arm	☐	☐	☐	_____
Pushing/pulling	☐	☐	☐	_____
Operating machinery /heavy vehicle	☐	☐	☐	_____
Driving a car	☐	☐	☐	_____

☐ Keep wound clean and dry

Other considerations (specify): _____

Restricted hours/days (specify): _____

☐ I require a suitable duties program to be provided to me for approval

PART E - Medical/Dental practitioner details (please print clearly or use practice or hospital stamp)

Doctor's name: _____ Practice/hospital name: _____

Postal address: _____

Preferred method of contact: ☐ Ph: _____ day(s)/time(s) _____

☐ Fax: _____ ☐ Email: _____

Signature: _____ Date: ___/___/___

Practice/hospital stamp here

Original signed copy – Insurer | Second copy – Employer | Third copy – Worker | Fourth copy – Medical/Dental Practitioner

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Tick ☑ if applicable, and fill in the information as requested.

☐ New claim

Claim number

PART A - Worker's details

I certify that on ___/___/___ I attended to (given names) _____

(surname) _____ (DOB) ___/___/___

Worker's daytime contact phone number _____

Worker's employer name _____

The worker is/was suffering from (list all medical/dental diagnoses relevant to the claim):

Diagnosis: _____

☐ This is a provisional diagnosis (**if provisional complete Part B**)

Worker was first seen at this practice/hospital for this injury/disease on ___/___/___

Worker stated date of injury ___/___/___

Worker's stated cause of injury (if not previously supplied): _____

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Injury/disease is consistent with worker's description of cause: ☐ Yes ☐ Uncertain

Detail any pre-existing factors or condition aggravated by the event (if not previously supplied):

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Worker's capacity for work (not only pre-injury duties)

Please consider the *"health benefits of work"* when certifying the worker's capacity

☐ To return to normal duties from ___/___/___

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☐ No capability for any type of work ___/___/___ to ___/___/___ (**complete Part C**)

Estimated time to return to some form of work duties: _____ ☐ days ☐ weeks ☐ unsure

Medical management

☐ Worker will require treatment from ___/___/___ to ___/___/___ (**complete Part C**)

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PART C - Medical management plan

Treatment: _____

Medication prescribed: _____

Referred to specialist (specialty/name): _____

Referred to allied health professional (discipline/name): _____

Detail (specify): _____

I would like the insurer to arrange a case conference with (tick more than one if appropriate)

☐ Treating practitioner ☐ Treating Specialist ☐ Treating Allied Health ☐ Employer

☐ Employer has been contacted

☐ I would like the insurer to contact me

Further information: _____

_____

PART D - Rehabilitation and return to work plan

☐ Approval is given for a suitable duties program with the following guidelines

	No	Occasional	Frequent	Comments
Lifting: weight limit ___ kg	☐	☐	☐	
Bending/twisting/squatting	☐	☐	☐	
Standing/sitting	☐	☐	☐	
Use of injured hand/arm	☐	☐	☐	
Pushing/pulling	☐	☐	☐	
Operating machinery /heavy vehicle	☐	☐	☐	
Driving a car	☐	☐	☐	

☐ Keep wound clean and dry

Other considerations (specify): _____

Restricted hours/days (specify): _____

☐ I require a suitable duties program to be provided to me for approval

PART E - Medical/Dental practitioner details (please print clearly or use practice or hospital stamp)

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Preferred method of contact: ☐ Ph: _____ day(s)/time(s) _____

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Claim number

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(surname) _____ (DOB) ___/___/___

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Medical management

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PART C - Medical management plan

Treatment: _____

Medication prescribed: _____

Referred to specialist (specialty/name): _____

Referred to allied health professional (discipline/name): _____

Detail (specify): _____

I would like the insurer to arrange a case conference with (tick more than one if appropriate)

☐ Treating practitioner ☐ Treating Specialist ☐ Treating Allied Health ☐ Employer

☐ Employer has been contacted

☐ I would like the insurer to contact me

Further information: _____

_____

PART D - Rehabilitation and return to work plan

☐ Approval is given for a suitable duties program with the following guidelines

	No	Occasional	Frequent	Comments
Lifting: weight limit ___ kg	☐	☐	☐	
Bending/twisting/squatting	☐	☐	☐	
Standing/sitting	☐	☐	☐	
Use of injured hand/arm	☐	☐	☐	
Pushing/pulling	☐	☐	☐	
Operating machinery /heavy vehicle	☐	☐	☐	
Driving a car	☐	☐	☐	

☐ Keep wound clean and dry

Other considerations (specify): _____

Restricted hours/days (specify): _____

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PART C - Medical management plan

Treatment: _____

Medication prescribed: _____

Referred to specialist (specialty/name): _____

Referred to allied health professional (discipline/name): _____

Detail (specify): _____

I would like the insurer to arrange a case conference with (tick more than one if appropriate)

☐ Treating practitioner ☐ Treating Specialist ☐ Treating Allied Health ☐ Employer

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☐ I would like the insurer to contact me

Further information: _____

_____

PART D - Rehabilitation and return to work plan

☐ Approval is given for a suitable duties program with the following guidelines

	No	Occasional	Frequent	Comments
Lifting: weight limit ___ kg	☐	☐	☐	
Bending/twisting/squatting	☐	☐	☐	
Standing/sitting	☐	☐	☐	
Use of injured hand/arm	☐	☐	☐	
Pushing/pulling	☐	☐	☐	
Operating machinery /heavy vehicle	☐	☐	☐	
Driving a car	☐	☐	☐	

☐ Keep wound clean and dry

Other considerations (specify): _____

Restricted hours/days (specify): _____

☐ I require a suitable duties program to be provided to me for approval

PART E - Medical/Dental practitioner details (please print clearly or use practice or hospital stamp)

Doctor's name: _____ Practice/hospital name: _____

Postal address: _____

Preferred method of contact: ☐ Ph: _____ day(s)/time(s) _____

☐ Fax: _____ ☐ Email: _____

Signature: _____ Date: ___/___/___

Practice/hospital stamp here