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| --- | --- |
| **Occupational Therapy****Initial Report &****Return to Work Plan** | **Surname:** \_\_\_\_\_\_**Given Name:** \_\_\_\_\_\_**Address:** \_\_\_\_\_\_**DOB:** \_\_\_\_\_\_ **Sex:** \_\_\_ **Claim No.:** \_\_\_\_\_\_\_\_ |

**Provider name:** Health Enhance Occupational Therapy **Provider no.** 038

**Provider address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone:** 1800 629856 **Email address:** RTW@Healthenhance.com.au

**Date of report:**

**Worker Details**

Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injury Date: \_\_\_\_\_\_

Pre-Injury Job Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Work Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pre-Injury Work Hours:\_\_\_\_\_\_\_\_\_

Ceased Work Date:\_\_\_\_\_\_\_\_\_\_\_

Capacity for work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RTW date (if applicable):\_\_\_\_\_\_\_\_\_\_Current Hours of Work (if applicable )\_\_\_\_\_\_\_\_\_

**Employer Details**

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial Report & RTW**

Contact Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DETAILS**

![C:\Users\miboujaoude\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\UZI7FHBI\42_as_Interleaved_2_of_5_barcode[1].jpg]()

**Agent Details**

Agent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agent Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Manager Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Manager Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**EATING MEDICA**

**L**

**Treating Medical Practitioner Details**

Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **RETURN TO WORK PLAN** |

**Expected RTW Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Return to work goals**

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|  |

**SUMMARY OF WORKER”S CURRENT STATUS**

|  |
| --- |
| **Injury Detail (include a summary of medical status)** |
|  |
| **Current Status (including summary of employment status; medical restrictions; current treatment)**  |
|  |
| **Functional Capacity and impact on RTW** |
|  |
| **Worksite Assessment (include description of pre-injury duties, work location, hours and suitable duties identified)** | **Date of Assessment:** |
|  |
| **Job Task Analysis:** |
| **Task (normal duties and tasks)** | **Critical Task Demands (currently fit to perform duties or not)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Identified Barriers and proposed solutions** |
| **Barriers**  | **Solutions** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Description of Suitable Duties**

|  |  |
| --- | --- |
| **Proposed duties and tasks of this plan, work location** | **Client’s ability to meet task demands** |
|  |  |
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| **GRADED RETURN TO WORK PLAN** |

**This plan is subject to review and medical approval from Nominated Treating Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Date** | **Hours** | **Duties** |
| **Week 1** |   | **Suitable Duties:****Restrictions:** |
| **Week 2** |   | **Suitable Duties:****Restrictions:** |
| **Week 3** |  | **Suitable Duties:****Restrictions:** |
| **Week 4** |  | **Suitable Duties:****Restrictions:** |
| **Week 5** |  | **Suitable Duties:****Restrictions:** |
| **Week 6** |  | **Suitable Duties:****Restrictions:** |
| **Week 7** |  | **Suitable Duties:****Restrictions:** |
| **Week 8** |  | **Suitable Duties:****Restrictions:** |

**RECOMMENDATIONS:**

Actions to be completed to enable the injured worker to return to work:

|  |  |  |
| --- | --- | --- |
| **Action** | **Person Responsible** | **Review Date** |
| Worker to work adhere to the following recommendations: |  |  |
| Employer to: |  |  |
| Sunnybrook Health to: |  |  |

This plan has been developed in consultation with (insert client and employers name)

**AGREEEMENT BY PARTIES AT THE WORKPLACE:**

I agree to the terms of this Return to Work Plan

**WORKER’S SIGNATURE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_/\_\_\_/\_\_\_

**EMPLOYER’S SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**DOCTOR’S SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**SUNNYBROOK HEALTH**

**THERAPIST’S SIGNATURE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

Name

Occupational Therapist