Corporate Solutions

Medical Certificate / Update

For completion by a Registered Medical Practitioner (please note: this is to be completed at the patient's expense).

1 Plan details

Plan name

Employer name

Claim number (office use only)

2 Member details

Full name

Date of birth DD / MM / YYYY

Mailing Address Street

Suburb

City

Postcode

Date of incapacity DD / MM / YYYY

3 Impairment and clinical management details

Original diagnosis

Present diagnosis

Please list any complications

4 Treatment details

Please list medications, dosages, and any diagnostic investigations undertaken since the last update

When was the last time the treatment regime was reviewed and altered?

When do you plan to review the treatment regime next?

Is a specialist medical opinion necessary at this time?

☐ Yes ☐ No

If Yes, in which discipline?

5 Return to work

The patient is fully unfit for work

☐ Yes ☐ No

If there is no fit to return to work date, please list the task at the patient's work they are not able to perform

The patient is fit to return to ☐ full-time work ☐ part-time or restricted* work on DD / MM / YYYY

*Please list any restriction of time or task, e.g. Light duties – Must avoid lifting over 10kg

Are you completing any other medical certificates for this patient?

☐ Yes ☐ No

If Yes, please give full details

Return to work continued...

Rehabilitation plan

At AIA we are committed to supporting optimal rehabilitation. We recognise the essential role of General Practitioner and would value your input developing a rehabilitation plan with our mutual client.

Patient's occupation at date of disablement

If employed, has the employer been contacted to discuss possible alternative duties? Yes No

If Yes or No, please give full details

If self-employed, have alterations to time or tasks been considered? Yes No

If Yes or No, please give full details

Has a graduated return to work plan been drawn up between you and your patient? Yes No

If Yes, please provide details

(e.g. 2 hrs/ day in week one, increase by 1 hr/day each week after that)

Are there any factors not related to the illness/ injury that are limiting rehabilitation?

(e.g. job satisfaction, relationship issues or lifestyle factors)

Would you like an AIA Medical Advisor or Case Manager to phone you? Yes No

Best day to call

Best time to call

Telephone

6 Attending Physician's Declaration

Full Name

Mailing Address

Street

Suburb

City

Postcode

Signature X

Date DD / MM / YYYY

Date examined DD / MM / YYYY

Next proposed review date DD / MM / YYYY

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