| INDIVIDUAL CASE MANAGEMENT PLAN | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| Case Management Plan No.: 1 2 3 4 5 | | | | | | |
| WORKER | | | | | | |
| Name (Last, First): | | | | Home Phone: | | |
| Occupation: | | | | | | |
| Date of Injury: Click here to enter a date. | | Claim No.: | | | | |
| Type of Injury/Diagnosis: | | | | | | |
|  | | | | | | |
| EMPLOYER | TREATING DOCTOR | | | | | |
| Name: | Name: | | | | | |
| Contact Person: | Phone No.: | | | | | |
| Contact No.: |  | | | | | |
| OTHER TREATMENT PROVIDER | OTHER TREATMENT PROVIDER | | | | | |
| Name: | Name: | | | | | |
| Phone No.: | Phone No.: | | | | | |
| BACKGROUND INFORMATION | | | | | | |
|  | | | | | | |
| CURRENT CERTIFIED CAPACITY FOR WORK | | | | | | |
| Unfit for all duties Fit for suitable duties Fit for normal duties | | | | | | |
| RETURN TO WORK GOAL | | | | | | |
| The injured worker shall return to pre-injury duties as a Click here to enter job title by Click here to enter a date. | | | | | | |
| MEDICAL & TREATMENT PLAN | | | | | | |
| **SERVICE/ACTION** | | | | **PERSON RESPONSIBLE** | | **REVIEW DATE** |
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| RETURN TO WORK PLANNING | | | Are suitable duties available? Yes No | | | |
| **SERVICE/ACTION** | | | **PERSON RESPONSIBLE** | | **REVIEW DATE** | |
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| COMMENTS AND ISSUES | | | | | | |
| This injured worker is to comply with his/her obligations outlined in this injury management plan. Please be aware that failure to do so may result in the suspension of benefits whilst the failure continues. Benefits ceased for non-compliance are not reimbursed following resumption of compliance.  This injured worker is to inform the case manager of any developments or changes in his medical, treatment and return to work planning.  This injured worker is to attend all medical appointments scheduled by the case manager.  Any difficulties encountered, or failure to comply with any aspects of this plan should be reported immediately to the case manager. Such an occurrence should not be viewed as a failure on any one party’s part, but rather an indication that further review and refinement of this case management plan may be required | | | | | | |
| REFERRAL | | | | | | |
| Referred to: Click here to enter a date. | | | | | | |
| Referred to: Click here to enter a date. | | | | | | |

This plan will be reviewed on Click here to enter a date.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Injured worker name), agree to this Injury Management Plan.

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

This Case Management Plan was developed by:

|  |  |
| --- | --- |
| Name: | |
| Title: | Telephone: |
| Signature: | Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |

Final certificate issued by attending physician? (circle) Yes No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_