CTP INSURANCE REGULATOR

Government of South Australia

Please print this medical certificate and take it to your doctor for completion. Make a copy and provide the completed certificate with your claim form.

This medical certificate must be completed by your treating doctor.

CTP Insurance Claims Medical Certificate

Patient family name / given name(s)

Date of birth | I examined you on: | for injury you stated occurred on:

Is the patient an existing patient of yours, or your medical practice, as at the date of the accident?

Yes, since ☐ No ☐

Motor accident details:

My clinical diagnosis(es) based on my examination of you and other information is:

Is this a: new injury ☐ exacerbation of a pre-existing injury or condition ☐ OR both ☐

Are the injuries consistent with the accident details: Yes ☐ No ☐ If no, give details

Functional ability: Your functional ability is affected by this injury(s)/condition(s) as follows:

Physical function	Can	With modification	Cannot	Mental health	Not affected	Partially affected	Affected
Sitting:	☐	☐	☐	Attention/ concentration:	☐	☐	☐
Standing/walking:	☐	☐	☐				
Keyboard/typing:	☐	☐	☐	Memory (short term and/or long term):	☐	☐	☐
Carrying/holding/lifting:	☐	☐	☐				
Reaching above shoulder:	☐	☐	☐	Judgement (ability to make decisions):	☐	☐	☐
Bending:	☐	☐	☐				
Use of affected body part:	☐	☐	☐	Other comments:			
Neck movement:	☐	☐	☐				
Climbing steps/stairs/ladders:	☐	☐	☐				
Driving:	☐	☐	☐				

Certification: In my opinion, you (please tick whichever apply)

☐ Have recovered from your injury and are fit to return to normal duties and hours on:

☐ Are fit to perform suitable duties that accommodate your functional abilities from: to

☐ Are medically unfit to undertake suitable duties for the period: to

I would like to review your progress on:

Treatment likely to be required:

☐ NIL ☐ Short term (<6 weeks) ☐ Medium term (6-12 weeks) ☐ Long term (>12 weeks)

Proposed treatment and investigation plan: The following plan is aimed at assisting your recovery:

Treatment / investigation	Details of provider	Duration likely required
Radiologist / imaging		
Therapy – physical		
Medical specialist		
Therapy – psych.		
Other		

I have prescribed medication(s) as a result of the accident Yes ☐ No ☐

Prescription details:

Medical practitioner details

Medical practitioner's name

AHPRA Registration number

Email address

Phone / Fax

Name of medical practice or hospital

Address

Postcode

I declare that I am a registered medical practitioner and I physically examined this patient. To the best of my knowledge the information provided here is true and correct

Professional qualification

Signature

Date

Fee schedule: Certificate completion can be charged under the Medicare Benefits Schedule: item number 00023, 00036, or 00044.