

Medical Assessment Letter For Work

To Whom it may concern,

The following staff member has presented for concussion assessment. Please see attached Return to Work Plan.

Staff Member's Name:

DOB:

_____ Has not sustained a concussion and is able to return to normal activity
_____ Has sustained a concussion

Date of Injury _____

To support recovery, it is recommended (select those applicable):

Complete the following	Tasks to Complete Following Concussion
	48 hours complete rest
	Gradual return to work, beginning with _____ hours per day.
	Provision of a quiet space at work to avoid noises
	Staff member may need to leave work if feeling poorly
	Staff member may need to take mini breaks during day/leave early as required
	Extensions or accommodations for work related tasks
	Avoid manual exercise for a period
	Other recommendations: - No driving until symptom free for 48 hrs - -

It is expected that symptoms should resolve and the individual be back to normal work routine with _____ weeks.

If symptoms persist or if you have any concerns, please refer the staff member back to the GP. Please support them in accessing further medical treatment/assessment for these.

Signed: _____

Date: _____