



## Occupational Health Employee Referral Form

### CONFIDENTIAL TO OCCUPATIONAL HEALTH To be completed by referring Manager

| Section 1: Notes for the referring manager  |   |
|---|---|
| <ol style="list-style-type: none"><li>1. The Occupational Health Department (OHD) provides an independent, confidential advisory service to both employees and the employer on all matters relating to the effect of health on work and work on health.</li><li>2. The reason for referral must be discussed with the employee in advance of the referral. The manager should sign section 8 and indicate that s/he has discussed this referral with the employee being referred.</li><li>3. To ensure the occupational health consultation is beneficial for all parties it is essential that all relevant background information is provided at the time of referral.</li><li>4. Managers must complete the sickness absence grid at Appendix A.</li><li>5. Once completed, the manager should send the form to the OHD. The OHD will contact the employee to arrange an appointment. Appointments will only be made on receipt of a fully completed referral form. Incomplete forms will be returned to the manager.</li><li>6. Managers can normally expect a written report following assessment within five working days of the appointment.</li><li>7. The OHD will discuss their findings with the employee which will then form the basis of a report to be submitted on a confidential basis to the referring manager, the employee and other designated key people for successful case management (eg HR).</li></ol> |   |
| Section 2: Employee details (use block capitals)  |   |
| Family Name:  | Forename(s):  |
| Date of birth:  | Gender:   |
| Employee/personal number:   | Email address:  |
| Home address:   | Contact telephone numbers:<br>Home:<br>Mobile:<br>Work:   |
| Section 3: Post details (use block capitals)  |   |
| Post/Grade:   | Department:   |
| Location:   | Usual hours of work:  |
| Work pattern:<br><input type="checkbox"/> Full time<br><input type="checkbox"/> Part time<br><input type="checkbox"/> Job share   | Night work:<br><input type="checkbox"/> None<br><input type="checkbox"/> Occasional<br><input type="checkbox"/> Regular |

**Section 4: Job demands (give details of physical demands, work hazards, location issues, other demands)**

**Section 5: Current medical issues**

Is the employee currently on sick leave? Yes  No

Is the employee currently under the care of a Consultant? Yes  No

When does the current medical certificate expire? \_\_\_\_\_

What is the certified reason given for this absence? \_\_\_\_\_

*Complete the sickness absence grid at Appendix A.*

**Section 6: Reason for referral (tick all relevant boxes)**

- Assess fitness to return to duty following sickness absence
- Frequent short-term sickness absence
- Long-term sickness absence
- Medical review of disclosed health issue
- Health-related performance issue
- Possible work-related health problem
- Accident/injury at work
- Infectious disease
- Suspected substance abuse
- Other, describe below

Describe the main issues, chronologically, that have initiated this request and any other relevant facts:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 7: Specific advice requested (tick the options that are most appropriate for the information that you require))**

- Is there an underlying medical condition affecting this individuals performance or attendance at work?
- Is s/he currently fit to carry out the duties outlined in the job description?
- Are there any short-term adjustments to the work tasks or environment that would help to facilitate rehabilitation or an early return to work?
- Are any permanent adjustments to the work tasks or environment recommended?
- What is the likely time-scale for recovery and/or when do you anticipate a return to work?
- Is there further requirement for medical support or intervention?
- Is the health problem likely to recur or affect future attendance?
- In your opinion, does the health problem meet the criteria for disability as defined by the Employment Equality Act?
- Will s/he be able to offer a regular and efficient service in the future, or is this health problem likely to recur or affect future attendance?
- Other information (please specify e.g. opportunities for job adjustment/redeployment, any outstanding

disciplinary/grievance procedures):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Section 8: Referring manager's details and checklist**

|                 |                               |
|-----------------|-------------------------------|
| Manager's name: | Address:                      |
| Job title:      | Department:                   |
| Contact number: | Email:                        |
| HR Manager:     | HR Manager's contact details: |

I confirm that I have discussed the reasons for this referral with the employee  
 The employee has received a copy of this referral and associated information sheets  
 I am aware that the employee will receive a copy of the resulting report  
 I enclose a copy of the employee's job description/job function analysis as appropriate  
 I attach a copy of the employee's sickness absence chart  
 I attach other relevant documents (please specify, eg details of return to work meetings, incident/accident forms) \_\_\_\_\_  
 \_\_\_\_\_  
 Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Note: Appointments will only be made on receipt of a fully completed referral form**

**Section 9: Employee's consent**

I confirm that my manager has discussed the reasons for this referral with me  
 I confirm that I consent to this referral and any subsequent appointment with the Occupational Health Department  
 I confirm that I consent to Occupational Health providing a report to my manager

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

**Section 10: Occupational Health use only**

|   |  |
|---|--|
| Referral reviewed by:   | Date:  |
| Further information required from:<br><input type="checkbox"/> Line manager<br><input type="checkbox"/> Employee<br><input type="checkbox"/> Medical Adviser/GP/Consultant<br><input type="checkbox"/> Other<br>_____ | Appointment to be offered in:<br><input type="checkbox"/> 1-2 weeks<br><input type="checkbox"/> 2-4 weeks<br><input type="checkbox"/> 4-6 weeks<br><input type="checkbox"/> Other<br>_____<br>Appointment with OHP OHA |

To be completed by Administrator:

Appointment date: \_\_\_\_\_ To be seen by: \_\_\_\_\_



