**Occupational Health – Management Referral Form**

**Employee Details – Who is being referred:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **DoB** |  |
| **Address** |  | | |
| **Email** |  | | |
| **Contact number** |  | | |
| **Job Title** |  | | |
| **Pronoun** |  | | |

**Employer Details:**

|  |  |
| --- | --- |
| **Business Name** |  |
| **Address** |  |

**Employee Job Details**

**Hours of work:** Full-time Part-time Shifts Nights

**Health hazards and risks, please tick all that apply and add in any not listed:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Tick |  | Tick |
| Driving |  | Noise |  |
| Emotionally demanding |  | Dust |  |
| Heights |  | Fumes |  |
| Confined spaces |  | Biological |  |
| Lone working |  | Moving and handling of items |  |
| Fast paced work |  | Stand or sit for most of the working hours |  |
| Repetitive movements |  | Aggression |  |

Other:

**Management reason for referral tick all that apply and add in others:**

|  |  |
| --- | --- |
| Short-term frequent sickness absences |  |
| Long-term (> 4 weeks) sickness absences |  |
| Performance issues – detail below |  |
| Fitness to work assessment |  |
| Fitness to attend disciplinary or other formal meeting |  |

Other:

**Detail performance and/or sickness absence details (briefly):**

**Details of the health reason for referral:**

**Tick which questions which you wish to be answered by the Occupational Health Advisor:**

|  |  |  |
| --- | --- | --- |
| **1.** | What are the health reasons that are impacting performance / attendance? |  |
| **2.** | Are the health issues affecting performance / attendance likely to improve or deteriorate in the next 12 months? |  |
| **3.** | Are there any adjustments that you suggest the business and employee consider to enable performance and / or attendance improvements? |  |
| **4.** | Is the employee fit to attend disciplinary or other formal meetings? Please advise on adjustments to assist with attendance. |  |
| **5.** | Does the employee have impairments to day to day living that have been or likely to be long-term (> 12 months) to be considered without treatment? |  |

**Other questions (add up to 5 only):**

**Does the individual have any communication barriers for instance deaf or English as a 2nd language?**

**NO**

**Does the individual have any mobility or access issues?**

NO

**Please send through sickness absence, job description and with employee consent copies of any Doctor or health specialist reports.**

**Referring person(s) details. The report will be sent to these people only and any discussions about the report content will only be able to occur with the below named people.**

Person 1:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Position** |  |
| **Email address for report** |  | **Contact no.** |  |

Person 2:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Position** |  |
| **Email address for report** |  | **Contact no.** |  |

**Declaration**

I declare that I have discussed the content of this referral form, reasons for referral, to whom the report will be sent and potential outcomes following the occupational health assessment, with the employee named in this referral form and obtained their consent (written or verbal) to the occupational health assessment.

**Name: Date:**

This referral form will form part of the employee clinical records. If the employee or other party (with the employee consent) requests a copy of the clinical records this referral form will be given to the requesting person.

The clinical case records are kept for 6-7 years after the last date of entry and then disposed of securely.