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# **Occupational Health Referral Form**

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| **REFERRAL DETAILS To be completed by HR/Manager**(NB: This form will form part of the medical file which the employee is entitled to see.Manager’s completing this form must consult the HR Business Partner for their Institute/Directorate prior to submitting this form.) |
| **HR Contact** |  | **Contact Tel:** | **Email:** |
| **Manager’s Name** |  | **Contact Tel:** | **Email:** |

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| --- | --- | --- | --- |
| **Name of Employee** |  | **Department** |  |
| **Date of Birth** |  | **Job Title** |  |
| **Home Address** |  |
|  |
| **Home/Mobile**  |  | **Email:** |  |

1. Previous records: Has this employee been referred to Occupational Health before, for any reason?
2. Please provide a description of the employee’s work responsibilities and duties (attach a job description if available)

The work has the following major features: (place an X in the relevant box)

|  |  |  |  |
| --- | --- | --- | --- |
| * Full time
 |  | * Working in isolation
 |  |
| * Part time (state hours)
 |  | * Sitting for long periods
 |  |
| * Management responsibilities
 |  | * Standing for long periods
 |  |
| * Computer use
 |  | * Handling chemicals
 |  |
| * Manual handling
 |  | * Mentally/emotionally demanding
 |  |
| * Working in temperature extremes
 |  | * Other (please specify)
 |  |
| * Physical demanding
 |  |  |  |

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| **Details of dates and reason for past and current sickness absence – 12 months history**  |
| **Date** | **No of days** | **Reason** |
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**Reason for referral (please put an X in the relevant box)**

|  |  |  |  |
| --- | --- | --- | --- |
| Long term sickness absence |  | Frequent short term absence |  |
| Work related accident/ill-health |  | Advice relating to Health and Safety Legislation |  |
| Concern over ability to perform duties |  | Review following previous referral |  |
| To determine fitness before or soon after return to work |  | Other (please specify) |  |

**Detailed reason for referral**

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**Advice required (Place an X in the box as required)**

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| --- | --- |
|  | What is the employee’s current state of health? |
|  | Are there any underlying problems causing or contributing to absence from work? |
|  | What is the likely date of return to work? |
|  | Are there any duties that the employee will not be able to perform on return to work? |
|  | What work restrictions and recommendations would you advise, including duration? |
|  | Advice on a graduated return to work programme outlining the timescales of each stage until resumption of full hours and duties |
|  | Should the employee be considered disabled under the terms of the Equality Act? |
|  | What suitable adjustments are needed to comply with the Equality Act? |
|  | What other support could the organisation consider that would assist the employee? |
|  | Should alternative employment be considered and if so what would be suitable? |
|  | Is the employee permanently unfit for the essential parts of the duties? |
|  | Can you advice on the employee meeting medical criteria for ill health retirement? |
|  | Other advice sought (please detail below) |

**I have informed the above-named employee of this referral, the reasons for the referral and I have informed the employee that an appointment will be arranged for them with Occupational Health.**

Manager’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Manager’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The information on this form should be regarded as confidential. Please send completed form to the HR representative managing the referral.**

**Further information on Occupational Health can be found on the website.**