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# Occupational Health Management Referral Form

**SECTION ONE – Referral Details**

| | |
|---|---|
| **COMPANY NAME:** | |
| **Referring Manager** | |
| **Position** | |
| **Contact Telephone Number** | |
| **Contact Email Address** | |
| **Date Referral Sent** | |

| | | | |
|---|---|---|---|
| **Employee Forename** | | **Employee Surname** | |
| **Job Title:** | | **Date of Birth:** | |
| **Hours Contracted** | | **Job Description Attached:** | |

**SECTION TWO – OCCUPATIONAL PHYSICIAN ASSESSMENT – please tick**

| | | | | |
|---|---|---|---|---|
| **CLINIC APPOINTMENT** | | **HOME VISIT** | **WORKVISIT** | |

| | | | |
|---|---|---|---|
| **Home Address** | | **Email** | |
| **Landline Number** | | **Mobile Number** | |

| | | | |
|---|---|---|---|
| **Workplace Visit** | | **Address:** if different from above | |
| **Line Manager Name:** | | **Line Manager Job Title:** | |
| **Line Manager Email:** | | **Telephone Number** | |

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|---|---|
| **Are there any contributing factors that need to be considered?** (the individual is undergoing disciplinary investigation, capability procedure and/or home related issues) | |

**SECTION TWO - Reason for Referral (please tick ☑):**

| | |
|---|---|
| **Changing job requirements** | |
| **Following accident or incident at work** | |
| **Mental health inc Stress/ Anxiety/ Depression** | |
| **Short Term Absence (Intermittent periods of Absence)** | |
| **Long Term Absence (Continuous)** | |
| **Present at work with a health condition that may require adjustments** | |
| **Other reason (please state)** | |

**SECTION THREE – Absence Details**

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|---|---|
| **Is this person currently in work?** | **Yes** |

**Sick absence details for the past 12 months (longer if appropriate)**

| **From:** | **To:** | **Reason given for absence:** |
|---|---|---|
| | | |

**SECTION FOUR – Background Information**

| **Comments and Statement** |
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| |

**SECTION FIVE - Information required from this referral (please tick ☑):**

| | | |
|---|---|---|
| 1. | Is he / she fit to carry out the full range of duties relating to his / her job? | |
| 2. | What is the likely period of recovery usually expected in relation to this illness? | |
| 3.<br><br>a)<br>b) | If he / she is not fit at present for his / her full range of duties, please advise on:<br><br>Their probable date of fitness to resume normal duties.<br>Whether restricted duties are required to facilitate a return to work as part of a rehabilitation programme. If so please advise. | |
| 4. | In your medical opinion, should there be anything else that we should consider as part of this phased return to work plan outlined, by way of recommendations? | |
| 5. | Is there a likelihood of on-going complications and absences from work? | |

| | | |
|---|---|---|
| 6. | Is there any need for on-going medical treatment/regular appointments? | |
| 7. | What is the anticipated time span for recovery, sufficient to enable a return to work? | |
| 8. | Is there any medical reason that would affect the individual's ability to participate in formal management process? | |
| 9. | Does the condition impose Health & Safety / Safeguarding risks to the staff and or students? If so in what way? | |
| 10. | Is other OH legislation likely to apply? (e.g. Work Time, Display Screen Equipment, Manual Handling, Pregnancy and Infant feeding, Noise or COSHH) | |
| 11. | Is this condition likely to be long term, meeting the requirements of the Equality Act 2010? | |
| 12. | Would re-deployment to a suitable alternative position enable an early and sustained return to work ? | |

**SECTION SIX – Employee Consent**

**The reason for this referral has been explained by:**

Name of Referrer: ..... Signature: ..... Date: .....

**I confirm the reasons regarding this referral have been discussed with me and I consent to a report being prepared by the Occupational Health Provider in relation to this referral. I accept information relating to this referral will be held under the rules governing Medical Confidentiality and the Data Protection Act.**

**If requested the physician's report will be sent directly to you for your consent before being passed to management. If after 21 days from the date of postage or emailing, comments have not been received the report will be sent to management in its present form unless consent is specifically withdrawn by writing to the address below.**

Employee's signature: ..... Date: .....