



**OCCUPATIONAL HEALTH MANAGEMENT REFERRAL FORM**

**PART 1- TO BE COMPLETED BY THE REFERRING MANAGER**

**DETAILS OF REFERRING MANAGER**

<b><u>DETAILS OF REFERRING MANAGER</u></b>			
Name of Company			
Name of Referring Manager			
Position of Referring Manager			
Date of Referral			
Telephone Number			
Employee fully informed of Referral			
Assessment Required (Please tick relevant box)	<b>Telephone</b>		<b>Physical</b>
Medical Personnel (Please tick relevant box)	<b>Doctor</b>		<b>Nurse</b>

**DETAILS OF EMPLOYEE**

<b><u>DETAILS OF EMPLOYEE</u></b>		
Name of Employee		
Date of Birth		
Address of Employee		
Telephone Number	<b>Home</b>	
	<b>Mobile</b>	
Employee's GP Name		
Employee's GP Address		
Employee's GP Telephone		

Number	
Position held by Employee	
Job Description of Position	
Start date	

<b><u>REASONS FOR REFERRAL – PLEASE TICK RELEVANT BOXES</u></b>	
Repeated short periods of absence	
Continuous sickness absence	
Fitness for work	
Report following an accident at work	
Job requirements have changed/ will be changing	
Poor work performance	
Suspected misuse of alcohol and/or drugs	
Other – please elaborate below:	

<b><u>DETAILS OF SICKNESS</u></b>	
Description of Sickness	
Effect of work (Please elaborate on any relevant background information)	

**INFORMATION REQUIRED BY REFERRING MANAGER**

Please tick the questions you wish the Occupational Health Physician/Advisor to address in this report

When can the employee return to work?	
How long can the illness/condition be expected to last?	
Is the illness/condition work related?	
Will the illness/condition affect the employee's daily activities?	
Will the employee be able to provide a reliable service in the future?	
Is the Disability Discrimination Act applicable and, if so, is there any advice that can be provided to ensure compliance with the Act?	
Will it be necessary to make special job adjustments in accordance with Health and Safety Regulations?	
Will there be any temporary or permanent work restrictions?	
Will specific steps be required to facilitate a return to work?	
Will redeployment be necessary for the employee?	
Is the employee fit to continue in their current position, or is the employee permanently unfit to resume work?	
Is ill-health retirement a relevant issue to be considered?	

Please elaborate on any other questions you wish to be answered by the Occupational Health Physician/Advisor:

**PART 2- CONFIRMATION- TO BE COMPLETED AND SIGNED BY BOTH THE REFERRING MANAGER AND THE EMPLOYEE**

I confirm that the employee has been fully informed of the referral process.

Manger:

Employee:

Signed:

Signed:

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\_\_\_\_\_

Date:

Date:

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