

Consent Form for referral of employee to Occupational Health



Consent Form for referring an employee to Occupational Health (to be submitted with Management Referral Form)

Section A: To be completed by referring Manager

I request a report to be made available to me by Workplace Health & Wellbeing relating to the health capacity of the Staff Member named below:

Surname:		First Names:	
Job Title:		DOB:	
Manager Name:		Manager Job Title	
Manager Signature:		Date:	

Section B: To be completed by referred employee

I confirm that the nature and purpose of the assessment has been explained to me. I understand the assessment may include a physical examination and / or additional tests as appropriate and their nature and purpose will be explained to me.

I confirm I understand that my signed consent will be sought by Occupational Health if a verbal or written report is required from my General Practitioner or Consultant.

I understand that as a condition of receiving occupational sick pay, I may be required to attend an Independent medical examination.

The Access to Medical Reports Act 1988 does not apply in this situation, as the doctor who examines you is not responsible for your clinical care, He/she is acting in an independent capacity as a medical adviser to your employer.

I consent to a report on my health capacity being made to the above named Manager and Human Resources by Workplace Health and Wellbeing.

Manager Name:		Manager Job Title	
HR Adviser:		Division:	
Staff Signature:		Date:	

Section C: To be completed during OH assessment

Response

The standard procedure at the end of the consultation is for the Doctor/Nurse to explain the proposed content of the Report for your Manager/Human Resources. In every case your comments will be taken into account.

I confirm that a copy of the report can be sent to the above named Manager/HR

I wish to view the report before it is sent to the line manager. I am aware that I would be required to collect the report from Workplace Health, Rouen Road, 24 hours following my appointment. In addition, I am aware that if I choose to respond to the contents of the report, I have up to 48 hours to do so. If no response is received within the stipulated timescales, I consent to the report being released. I am also aware that the doctor / nurse can only amend factual inaccuracies and not opinions.

Please indicate your preferred report format (please indicate one only):	By postal services to your home address:	If yes tick here:	OR	Via secure encrypted email (please write your email address in this box):	If yes tick here:

Consent: Verbal / Written

Staff Signature:		Date:	
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