Management Referral Form



	Revision Date: February 2012										
Section 1	: Employe	e Details									
Surname			First Names:								
Title:			Date of Birth:								
110.			Bate of Birth.								
Home Address:		Home Telephone :									
		Job Title:									
Mobile Telephone:											
Company:		Work Location:									
Hours (FT/ PT)		At work / Off sick									
			Sickness Start								
Shift Pattern:			Date:								
		for Referral			Response						
	1	ss absence, please provide a sickness report	t or give details of abse	nce							
2.1		rt Term Sickness Absence									
2.2		n Sickness Absence									
2.3		egarding fitness for work in current position									
2.4		er an accident / injury sustained at work - pleas	e attach details								
2.5	-	nce Deterioration									
2.6	Other (ple	ase specify below)									
Absence Details											
Details											
		s (please expand rows to fit text as required)			Response						
Please p	rovide a br	ief description of the main job activities and	hazards that are requir	ed to undertake within their current position.							
Papaata	Instight bo	ndling			1						
	l patient ha	of inanimate objects									
		en Equipment									
	brating tools										
		atient transportation									
Contact with Respiratory / Skin sensitisers / irritants Exposure Prone Procedures (Healthcare organisations)											
	Exposure to Blood / Body Fluids										
Food Handlers											
Others (p	lease list be	elow)									
		und (please expand rows to fit text as require			<u> </u>						
		nprehensive and relevant information / conce nown to the individual employee)	erns regarding the reas	on for referral (NB: all the information on this for	m may be						
Section	• Other is	sues / performance (please expand rows to f	it text as required)								
		sues / performance (please expand rows to fi ing disciplinary / performance issues with th		lease provide an outline							
Ale uleft	any ongo	אווו שישטע איז	io mannadar: 11 yes - pl								

Section 6: Guidance											
Please indicate which areas you wish to be considered and require guidance on within the OH assessment											
6.1											
6.2											
6.3	6.3 Is this person likely to be fit to return to work in the next 4-6 weeks?										
6.4 If this person is not fit at present for his / her full range of duties, please advise on:											
	a) Likely time scale when able to resume										
	b) Recommendations for restricted duties										
	c) Recommendations on alternative temp				aken?						
6.5	If this person is permanently unfit for their										
	a) Whether re-deployment would allow a within a redeployment role?	return to w	ork - if Ye	s, please advise	e on the type of work activities that could be considered						
b) If a return to work were not possible, should an application for ill health retirement be considered?											
6.6 Is this person suitable for night work (Working Time Directive)?											
6.7 Factors to consider in reference to the Equality Act 2010											
	a) Does the employee a physical or ment										
	b) How long has it lasted or how long is it										
				day-to-day activi	vities?. If yes, please indicate how it impacts.						
					of staff in returning to work/remaining at work and the						
	reasons for this advice?	,	5								
Section	7: Additional Questions (please expand	rows to fit	text as r	equired)							
	ve any additional questions, please indi										
Section	8: Report Information (For Managers)										
l am refe	erring the person named above to Occup	oational He	ealth for a	assessment and	d can confirm that he/ she has been made fully						
	f the purpose of the referral and that you				erral to the employee tional Health' to the employee and this will be forwarded						
to Occup	ational Health.										
	ndicate your preferred report format (ple				Electronic copy via encrypted						
indicate	one only):		Postal Ha	rdcopy:	OR email:						
Name of	Manager:			Job Title:							
Email Ad				Telephone:							
Postal Ad	dress:										
				Talanhanai							
	ser Name:			Telephone:							
Email Ad											
Deetel A	1draaa.										
Postal Ad											
Date:				Signed :							
	ts will be posted / emailed to the Referri	ina manaa	er / HR a		ensure accurate information is provided above and the pr	eferred					
Аптеро	to will be posted / entailed to the Referr	ing manag				ciciica					
Please N	lote:										
1 Under the Data Protection Act 1998 employees may request access to their occupational health records.											
2 All referrals must be accompanied by a signed consent form.											
3											
ľ	an individual's specialist or GP and they consent to us accessing this information, there will be a delay in the report being prepared. Under these										
	circumstances we will write or e-mail you			•	, service of the other	-					
This form					ata (if appropriate), Incident form (if appropriate)):						
Workplac	ce Health & Wellbeing, 20 Rouen Road, No										
OR by Fax (secure) to:											
Fax No: 01603 287026											