The Health Alliance @ Brigstock

Medical Practice

Occupational Health referral form

Thank you for your enquiry. Please see below the Occupational Health Referral form, which you need to complete regarding your employee. Please provide as much detail as possible to enable us to carry out a full assessment and be able to address the questions/concerns that you have. Please put in detail the questions you wish to be answered in relation to your employees current health condition (or in relation to the reason for the referral)

Please ensure the employee has a copy of the referral form and understands what the process will be.

Upon receipt of the referral form, we will arrange for an Occupational Health appointment for your employee, with a qualified practitioner. A member of the team will confirm the appointment details to you via email and send a letter to your employee.

Please note, once the appointment has been confirmed, if this is cancelled with less than 24 hours notice, a fee of £100 will be charged.

Following the appointment, a report of the assessment will be sent to your employee in the first instance, as it is a requirement that they review the report, under the Medical Reports Act, providing their consent that they are happy with the content, before this is sent to you, as their employer.

Once we are in receipt of their authorisation, a copy of the report will be emailed to you.

Please note, an email will be sent to you to confirm they attended the appointment and that a copy of the report has been sent to the employee.

If at any stage of the process you have any questions or concerns, please do not hesitate to contact a member of the team on 07970 949346

Regards

**The Health Alliance Team**

**To be completed by the line manager and sent to:**

# (marked private and confidential) to Dr Shoby Sathananthan, Brigstock Medical Practice, 141 Brigstock Road, Thornton Heath, CR7 7JN

# **Please ensure this referral form is fully completed to assist the Occupational Health clinician in providing you with a comprehensive report.**

|  |
| --- |
| **Referring Manager Details                           Date:**  |
| Name, job title and address:  | Company |
| Tel | : |
| E-mail:  |
| Signature:  |
| **Employee Details** |
| Name: |  |
| Home Address: |  |
| Date of Birth: |  |
| Is the employee at work or off sick at present? Is absent, please state date absence started |  |
| Telephone No to be contacted on: |  |
| Job Title: |  |
| Hours of work/working pattern: |  |
| Date of commencementWith the organisation: |  |
| Are there any specific requirements needed to assist in this assessment? (i.e. an interpreter)If yes, please specify: |
| **Job Description**Please describe duties of their role or attach a copy of the job description. Does their role contain any of the following?  |
|                                                    Yes     no                                                         yes       no

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Manual handling  |   |   | Driving PCV/LGV |   |   |
| Nursing care of clients |   |   | Shift work |   |   |
| Classified DSE user |   |   | Chemicals (solvents) |   |   |
| Clinical waste handling |   |   | Use of machinery |   |   |
| Child care |  |  | Dealing with the general public |  |  |
| Managerial/supervisory role |  |  | Other (please specify) |  |  |

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| **Attendance Record**Please give details of the employee’s absence record for the previous 12 months if applicable and the reason for the referral |
| Dates and number of day’s absence together with reason(s) |  |
| **Reason for Referral (Please  all appropriate)** |
| Long term sickness absence |   | Frequent short term sickness absence (data must be included to assist the OHD assessment) |   |
| Concerns with work capability/performance |   | Mental health issues including stress |   |
| Workplace assessment |   | Ill health retirement assessment |   |
| Alcohol and substance misuse(we cannot discuss this with staff unless the manager has discussed their concerns with the employee first) |   | Accident/incident at work (please specify) |   |
| Return to work after an operation (please specify which operation if known) |   | Specific advice regarding the Equality Act 2010 |   |
| Other (Please state below)Return to work following attendance to hospital – please see below email received |   | Access to support services |   |
| **Please provide details of how the current problem is affecting their work** |
|   |
| **How long has the problem been present?** |   |
| **What remedial action have you taken?** |
| . |
| Provide information of any performance/capability/disciplinary concerns at work? |
| Please give details of any supportive measures and copies of any informal meeting notes as this helps the OH clinician understand the whole situation. Please also state if the individual has been referred to an Occupational Health Service previously? n/a |
| **Specific questions you would like answered (please list and continue on a separate sheet if necessary?** |
|   |

**In accordance with our policy please confirm that the reason for this referral has been fully explained to the employee and they have received a copy of this referral.**

**Yes/No**

Please confirm if any additional information is being provided i.e. GP report, previous medical reports, medical history, sickness certificates, etc.

Please also confirm if enclosing additional information, that you have gained your employee’s consent.

Signed:

Name:

Job

Date: