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MANAGEMENT REFERRAL TO OCCUPATIONAL HEALTH SERVICE

*Please complete all sections of this form to enable a comprehensive reply from the examining medical professional and to avoid any delay*.

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| SECTION 1: INDIVIDUAL DETAILS | | | | | |
| Title: | Choose an item. | | | | |
| First Name: |  | | Last Name: |  | |
| Date of birth:  (dd/mm/yyyy): |  | | **Preferred contact method:** |  | |
| Job title: |  | | Department: |  | |
| **Staff number:** |  | | Staff Category/Type: |  | |
| **Telephone No:** |  | | Mobile No: |  | |
| **Email address:** |  | | | | |
| **Number of hours worked/week:** |  | Working Pattern: | | |  |
| **Provide a brief description of the work involved. If relevant to the Occupational Health referral, highlight any particular demands or pressures from the role/working environment.** | | | | | |
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| **Does the employee have any other role in QUB or elsewhere?** | | Yes | | | No |
| **If yes please provide details:** | |  | | | |

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| SECTION 2: REFERRAL DETAILS | | | |
| Date of referral:  (dd/mm/yyyy): | | Click or tap to enter a date. | |
| **Current status** | | | |
| **At work:** |  | | |
| **Absent on sickness absence:** |  | **Date Commenced:** | Click or tap to enter a date. |
| **Absent but now returned:** |  | **Return date:** | Click or tap to enter a date. |
| If **at work** detail how the reported issue is affecting ability to work and detail any ongoing restrictions. | | | |
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| Please outline clearly the reason for referral (including relevant case history, relevant periods of absence and reason for absence, demands/pressure of the role and if person has been previously referred) | | | |
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| If work related stress is reported please identify & record the workplace stressors and what action you have taken to resolve the issues. | | | |
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| If personal stressors are reported please provide details and what action you have taken to support the employee. | | | |
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| Does the member of staff attribute the illness/absence to an accident/incident at work? | | | YES / NO |

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| SECTION 3: SICKNESS ABSENCE HISTORY  Please provide sickness absence for past 2 years  This section must be completed. Absence printouts will not be accepted | | |
| **Dates** | **Working days lost** | **Reason for absence** |
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| **SECTION 4: ACTION TAKEN** |
| Please specify previous action you have already taken to improve the employee’s attendance, including any adjustments (i.e. phased return to work/change of working pattern/part time working/change in duties or temporary reallocation of work duties etc). Please include any previous recommendations made by the Occupational Health professional which have been actioned. |
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| **SECTION 5 QUESTIONS FOR OH**  It is important that you ask the questions which would assist you with the management of this case. This gives us a clear basis for an OH assessment and will ensure that you receive an OH report which addresses your concerns. To assist you, some standard questions are provided below.  **Please indicate by ticking which questions you would like to be answered** | |
| Is the employee fit for work? |  |
| Is the employee currently unable to be at work due to ill-health or some other reason?  Please specify. |  |
| Is the individual likely to return to work in the foreseeable future?  Please specify when the employee will be fit for work. |  |
| Does employee have an underlying medical condition? |  |
| Has the medical condition lasted, or is it expected to last, for 12 months or longer? |  |
| To what extent does the medical condition have a substantial and long term adverse effect on the employee’s ability to carry out normal day-to-day activities and which would impact on their ability to provide regular and reliable service? |  |
| Does employee require any workplace adjustments (and if so for how long) which you think should be considered to assist with return to work and/or to maintain a regular and reliable attendance at work?  ***Please refer to section 4. Action Taken.*** Please outline any adjustments that you may be able to offer. |  |
| Is there any action the employee can take to assist in their recovery? |  |
| Is this person a potential candidate for ill health retirement? |  |
| Is the employee fit to attend a meeting/hearing regarding their employment? |  |
| Does the employee require any reasonable adjustments to attend this meeting? I.e. Off site meeting, conference call etc. |  |
| **Please outline below any additional questions that you require the OH Consultant to answer.** | |
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| **SECTION 6 DECLARATION**  **THIS SECTION MUST BE COMPLETED BEFORE THE MANAGEMENT REFERRAL CAN BE PROCESSED.** | |
| I confirm that the details of this referral have been discussed in full with the employee |  |
| I confirm that the employee has received a copy of this referral form prior to OH appointment |  |

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| **SECTION 7 Referring HR and Line Manager Details**  ***NB: For reasons of patient confidentiality OH reports can ONLY be forwarded to the referring manager(s)*** | |
| **HR (lead) Contact Details** | **Line Manager (Alternative) Contact Details** |
| A/HRBP Name: | Line Manager Name: |
| Contact Number: | Contact Number: |
| Email Address: | Email Address: |

***Please ensure ALL sections are completed and a job description is attached. Failure to do so may result in the referral being returned.***

**Email completed form to** [**HR**](mailto:occhealth@qub.ac.uk) **Business Partner who will forward to Occupational Health**