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| **Occupational Health Service (OHS) Student Referral Form**  **Fitness to Continue in Study (Study, Assessment and/or Placement)** |

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| Please complete sections 1 to 7 of the form taking the following guidance into consideration:   * Only detail factual information that is pertinent to the referral * Attach any supporting medical evidence or advise student to bring any relevant medical evidence to the OH Assessment * Remember that all information detailed on the form will be shared with the student |

1. **Student Details**

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| Title |  | DOB |  |
| Forename |  | QUB Email Address |  |
| Surname |  | Contact Number |  |
| Student Number |  |

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| --- | --- | --- | --- | --- |
| Course of Study |  | | | |
| Faculty & School |  | | | |
| Level and Year of Study |  | | | |
| Full-time or Part-time |  | | | |
| Registered with Disability Services  ***\*Please tick as appropriate*** | Yes |  | No |  |
| Reason for Referral  ***\*Please tick appropriate box(es)*** | Fitness to  Study |  | | |
|
| Fitness to undertake Assessment |  | | |
|
| Fitness to attend Placement |  | | |
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1. **Study Status**

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| --- | --- |
| Currently in Study |  |
| Currently on Placement |  |
| On leave of Absence  ***\*Date absence commenced & expected return date (if known)*** | **Date absence commenced:**  **Expected return date (if known):** |
| Absent but now returned  ***\*Date absence commenced & date returned*** | **Date absence commenced:**  **Date of return:** |
| Returning to Study Assessment ***\*Date absence commenced & proposed return date*** | **Date absence commenced:**  **Proposed return date:** |

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| If in study or on placement, please detail the reported problem and how it is affecting ability to participate. Please also detail any on-going restrictions or adjustments. |
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| If absent for any period, detail dates, duration and the reason(s) given for absence. |
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1. **Questions for OHS**

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| It is particularly important that questions are asked that will assist in the management of the student case. This gives a clear basis for an OH assessment and will ensure that the OH report addresses the key concerns. To assist some standard questions are detailed below.  **Please indicate by ticking which questions need to be answered.** |

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| Is the student fit for: | Study |  |
| Assessment |  |
| Placement |  |
| If not, when will the student be fit for: | Study |  |
| Assessment |  |
| Placement |  |
| Does the student require any adjustments to return to: | Study |  |
| Assessment |  |
| Placement |  |
| Giving due consideration to academic and professional practise standards, please outline the adjustments that can or cannot be considered to enable participation on the student’s chosen course of study: | **Can be accommodated** | **Cannot be accommodated** |
|  |  |
| Does the student have a medical condition that would impact on their ability to participate regularly in: | Study |  |
| Assessment |  |
| Placement |  |
| Any additional questions, please state: |  | |
| Please detail the date which the School needs outcome of Fitness to Continue in Study decision |  | |

1. **Additional Information**

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| Please detail any additional information that would support the OH Assessment (e.g. overview of academic, assessment and practise performance, University or Professional Standard Regulations of relevance, conduct issues, etc. |
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1. **Referring Staff Details**

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| --- | --- |
| **Name and Job Role of primary staff member raising referral** |  |
| **Contact Number of primary staff member raising referral** |  |
| **Email of primary staff member raising referral** |  |
| **Date of Referral** |  |

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| --- | --- |
| **Name and Job Role of secondary point of contact in School** |  |
| **Contact Number of secondary point of contact in School** |  |
| **Email of secondary point of contact in School** |  |

1. **Student Disability and Wellbeing**

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| **All referrals to OHS under Fitness to Continue in Study must be supported by Student Disability and Wellbeing Service. Please provide details of team member supporting this referral.** |

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| Supported by: |  |
| Job Title |  |
| Email Address |  |
| Contact Number |  |

1. **Student Knowledge**

NB: THIS SECTION OF THE FORM NEEDS TO BE COMPLETED BEFORE A STUDENT REFERRAL CAN BE PROCESSED.

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| Please place a tick in the box to confirm that the student is aware that a referral is being made and the reason(s) for this |  |

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| Please ensure sections 1 to 7are complete. Failure to do so may result in the referral being returned. If information being requested is ***NOT APPLICABLE***, note: ***N/A*** |

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| Please Note: SharePoint is used to securely process referrals and reports to and from the University’s OHS but should not be stored on the SharePoint site |