Valentine Occupational Health Limited
Management Referral Form

This form should be completed when submitting a management referral to Occupational Health.
This form will be used as the basis of the discussion between the Occupational Health Clinician and the individual employee, therefore please ensure all relevant sections of this form are completed as fully and accurately as possible. ***Incomplete or inappropriate referrals will be returned with appropriate advice. Please refer to our 'Employer Guidance for OH Assessment' for assistance.***

Basic Details of Individual Being Referred

Title	
First Name / Surname	
Known as	
Employer ID (Employee Specific ID)	
Date of Birth	
Employer	
Employee Address Details	
Home Phone / Mobile	
Email Address	
Notes	
Employment Dates **Role Started / Role Ended etc**	
Employment Details	
Occupation / Job Role	
Work Location	
Employment Terms	Full-time ☐ Part-time ☐ Job share ☐ Other ☐
Referred Contact Number	
Preferred Consultation Method	
Are there any dates the employee is not able to attend an OH Assessment?	

Risks Associated with Role

Please tick **all** relevant boxes

Deskwork ☐	Noise ☐	Office ☐	Management of staff ☐
Standing ☐	Dust or fumes ☐	Outdoors ☐	Psychological stressors ☐
Lifting or carrying ☐	Chemicals ☐	Offsite ☐	Vibrating Equipment ☐
Computer work ☐	Biological hazards ☐	Mobile at site ☐	Skin Irritants ☐
Field Work ☐	Work at heights ☐	Repetitive tasks ☐	Travel abroad ☐
Night Working ☐	Work in confined spaces ☐	Lone Working ☐	
Sedentary ☐			
Operating Dangerous Equipment/Machinery ☐			
Working with vulnerable adults and/or children ☐			

Other ☐ If other checked please expand below:

Driving

Vocational driving ☐ FLT ☐ LGV/PSV ☐

Other ☐ If other checked please expand below:

Current Absence Period (If applicable)

(To be completed where individual is absent from work at point of completing referral). (If employee is still in role please state).

Absence Start Date	
Reason for absence	

Overview of Absence Record

Please provide details of the employees' absence in the preceding 12 month rolling period including dates of absence and reasons.

Does the employee have access to company paid Medical Insurance and/or Heath Cash Plan or Physiotherapy service?

Yes ☐ No ☐ Other ☐

Does the employee have access to an EAP (Employee Assistance Programme) Service provided by the employer?

Yes ☐ No ☐ Other ☐

Does the employee have access to a Mental Fitness App provided by the employer?

Yes ☐ No ☐ Other ☐

Reasons for Referral – Please select the reason(s) for referral below

☐ Long term sickness absence – usually defined as continuous absence of 4 weeks or more.
☐ Recurring short term absences – based on episodes and their frequency e.g. Bradford formula.
☐ Concerns over work performance – poor or reduced performance levels where there may be a health problem.
☐ Investigation of work-related illness/injury – assessment of whether a health problem is likely to be work-related or not.
☐ Substance abuse concerns – assessment of suspected or admitted to substance abuse affecting work.
☐ Ill-Health Retirement assessment – whether the scheme ill health retirement criteria are met.
☐ An employee is about to be transferred to another job or is about to be promoted and a medical assessment is required.
☐ Assess an employee for fitness to attend a disciplinary meeting or other formal meeting
☐ Other Health concerns, please detail below

Questions below for Occupational Health Practitioner to advise/provide guidance on within subsequent report (Please tick questions you would like responses on):

☐	Is there an ongoing underlying medical condition (is the condition temporary/short-term, reoccurring, chronic/long-term)?
☐	Is the individual fit for work?
☐	Are you able to suggest of any adjustments that the workplace could consider to support the employee at work or to assist in a return to work?
☐	Possible impact the medical condition could have in the employee's ability to provide regular and efficient service in the future?

☐	Is the Equality Act (disability) 2010 likely to apply?

Specific Questions/Supportive comments:
(We cap additional questions at 5, 10 including the 5 above)

Referring manager has confirmed that:
They have discussed the reasons for the referral with the employee.
They have discussed possible outcomes.
The employee has agreed to attend an OH Assessment (by telephone or in person).

☐ **I confirm I have discussed this referral with the individual and they have given verbal or written consent to take part in an OH consultation. I am aware that this information will be shared with the individual during OH appointments and will form the basis of the consultation.**

Employee Signature…… Date……

Manager/HR Signature…… Date……

IMPORTANT: The outcome report will be released to the following contact(s):

Line Managers Name	
Line Managers Telephone Number	
Line Managers Email Address	
Name of HR Representative	
Contact number for HR	
Date of Referral	