

Management Referral Form

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| *This form is confidential to the Occupational Health Service. It should be completed by the manager responsible for the employee and sent either by internal mail to Occupational Health Service, 117A, JJ Thomson Building, Whiteknights Campus or via email to* *occupationalhealth@reading.ac.uk* |

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| Section 1: Managers Details  |
| Full Name  | Click here to enter text. |
| Job Title |  |
| Academic School or Service Department | Click here to enter text. |
| Work address | Click here to enter text. |
| Email address | Click here to enter text. |
| Daytime contact telephone number  | Click here to enter text. |
| HR Partner to be copied on report  | Click here to enter text. |

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| Section 2: Details of the employee  |
| Full Name  | Click here to enter text. |
| Job Title | Click here to enter text. |
| Academic School or Service Department | Click here to enter text. |
| Date of Birth | Click here to enter text. |
| Home address | Click here to enter text. |
| Email address | Click here to enter text. |
| Daytime contact telephone number  | Click here to enter text. |
| Please indicate any known dates when employee will not be available for assessment *(in the next 3 weeks)*  | Click here to enter text. |

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| Section 3: Reason for referral  |
| ***Background information about referral E.G reason for referral, details of absence, changes in health etc.:*** |
| Click here to enter text. |
| Sickness and absence* Recurrent short spells of absence or
* Prolonged sickness and absence
 | [ ] [ ]  |
| Fitness for work | [ ]   |
| Fitness to attend a meeting at work  | [ ]   |
| Report after accident at work  | [ ]   |
| Job requirements will be changing/have changed | [ ]  |
| Member of staff has declared they have a medical problem | [ ]  |
| Consideration of Ill Health Retirement | [ ]  |
| Employee has developed a disability for which advice on the management of the disability and adaptations are required | [ ]  |
| Concern about a member of staff’s health in relation to their ability to carry out their job  | [ ]  |
| Suspected alcohol or drug misuse | [ ]  |
| The employee has had a DSE assessment and they have declared they have a medical condition which requires an Occupational Health Assessment | [ ]  |
| Please attach a copy of the individual’s sickness record if available |

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| Section 4: Information RequiredWhat information would you like Occupational Health to provide you with (*please tick the boxes if required*) |
| Likely date of return to work? | [ ]   |
| Is the ill health work related? | [ ]  |
| Do any temporary or permanent restrictions apply and for how long? | [ ]  |
| Is the case covered by disability legislation and if so, what adjustments should be considered? | [ ]  |
| Will this person give reliable and consistent service from now on? | [ ]  |
| Is performance significantly affected by ill health and for how long is this likely to continue? | [ ]  |
| Is the employee fit to continue in their current post? | [ ]  |
| Is there a need to seek an alternative post? If yes is there any specific recommendation? | [ ]  |
| Is there any evidence that the work environment is contributing to sickness absence? If so what alterations may be beneficial? | [ ]  |
| Is ill health retirement relevant?  | [ ]  |
| Other (*please enter details below)* | [ ]  |
| Click here to enter text. |

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| Section 5: Activities of the employee*Is the employee involved in the following?*   | YES | SOME | NO |
| Standing for periods of time | [ ]  | [ ]  | [ ]  |
| Walking  | [ ]   | [ ]   | [ ]   |
| Climbing  | [ ]   | [ ]   | [ ]   |
| Working in confined spaces | [ ]   | [ ]   | [ ]   |
| Exposure to significant work place stress | [ ]  | [ ]  | [ ]  |
| Lifting or carrying heavy items | [ ]  | [ ]  | [ ]  |
| Handling food (including work in cold environments)  | [ ]  | [ ]  | [ ]  |
| Computer work or other display screen equipment | [ ]  | [ ]  | [ ]  |
| Prolonged sitting | [ ]  | [ ]  | [ ]  |
| Vocational driving | [ ]  | [ ]  | [ ]  |
| Driving fork lift trucks | [ ]  | [ ]  | [ ]  |
| Driving Light Goods or Passenger Carrying Vehicles | [ ]  | [ ]  | [ ]  |
| Occasional overseas travel | [ ]  | [ ]  | [ ]  |
| Frequent overseas travel or extended periods of travel | [ ]  | [ ]  | [ ]  |
| Work outside | [ ]  | [ ]  | [ ]  |
| Work in a noise hazard area | [ ]  | [ ]  | [ ]  |
| Working or coming into contact with chemicals | [ ]  | [ ]  | [ ]  |
| Working or coming into contact with biological agents | [ ]  | [ ]  | [ ]  |
| Working with skin irritants or sensitisers | [ ]  | [ ]  | [ ]  |
| Working with dusts or hazardous fumes | [ ]  | [ ]  | [ ]  |
| Working with animals | [ ]  | [ ]  | [ ]  |
| Working with substances hazardous to the unborn child or pregnant women | [ ]  | [ ]  | [ ]  |
| Working with dangerous machinery  | [ ]  | [ ]  | [ ]  |
| Works nights or shift work | [ ]  | [ ]  | [ ]  |
| Other, *please provide details*  |
| Click here to enter text. |
| Please attach a job description if available.  |

**Signature of referring manager:**

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| Signed | **Date** |
|  | Click here to enter a date. |
| Please confirm the employee has been made aware of the referral by ticking the box [ ]  |

**Confirmation that the referred employee understands the reasons for the referral:**

* *I confirm that I have read and understood the reason for referral.*
* *I also understand that following the appointment, Occupational Health will send a report to my manager and the HR partner specified above.*
* *I understand a summary of the report may also be sent to H&S Services if a medical condition has been caused or made worse by my work activities*
* *I understand that I may elect to see the report before it is supplied to my employer and will be given the opportunity to do this when I sign the consent form at the appointment.*
* *I understand that if I don’t give my consent for the referral, or the report, then the University will act solely on the information available.*
* *I understand that all recommendations contained in the report are recommendations only and it is the responsibility of my line manager to decide what advice is implemented, particularly in relation to determining reasonable adjustments to my work environment and/or to my job/role.*

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| Signed by the employee | **Date** |
|  | Click here to enter a date. |