

Management request for an Occupational Health Opinion

Section A Employee Personal Details	
Title Mr ☐ Mrs ☐ Dr ☐ Ms ☐ Miss ☐ Other	Sex: Male: ☐ Female: ☐ Indeterminate/intersex/unspecified: ☐
Surname:	First name:
Previous names (if applicable):	Date of birth:
Home address:	
Post code:	Email:
Mobile telephone:	Home telephone:
Name of GP:	GP telephone:
Address of GP:	
Section B Job Details	
Job Title:	
Ward/department:	Division:
Site:	Work telephone:
Date of commencement in post:	
Section C Requesting Manager Details	
Name:	Job Title:
Ward/department:	Site:
Address:	
Telephone:	Email:

Section D**Job Demands** (tick as appropriate)**Physical demands of job:**

- ☐ Office based
- ☐ Regular lifting duties
- ☐ Standing for long periods of time
- ☐ Walking long distances
- ☐ Computer work
- ☐ Driving
- ☐ Fork lift truck driver
- ☐ Regular shift work
- ☐ Regular night work
- ☐ Control and restraint issues
- ☐ Emotionally demanding

Work environment:

- ☐ Contact with bodily fluids
- ☐ Contact with biological hazards
- ☐ Contact with chemicals
- ☐ Food handler
- ☐ Exposure to dust or fumes
- ☐ Exposure to noise
- ☐ Working at heights/confined spaces
- ☐ Use of vibrating tools
- ☐ Exposure to verbal/physical aggression
- ☐ Protective clothing required (please specify)
- ☐ Extreme temperatures

Please provide details of any specific workplace issues relating to identified areas above

Section E		Reason for Referral	
Currently in work	☐ Yes	☐ No	
Reason for referral: ☐ Long term absence			
- Date absence commenced: ___/___/___ - Date current fit note up until: ___/___/___ - Reason for absence stated on most recent fit note: _____			
☐ Short term frequent absence			
☐ Health condition affecting work fitness			
☐ Other (please state) _____			
Please provide further details:			
If the reason relates to a musculoskeletal condition please also complete section F to give more detail			
If the reason relates to a mental ill health condition please also complete section G to give more detail			
Sickness Absence Record (please attach relevant details for the past 12 months including reasons for absence, length of absence, time absence began:			
Details of any perceived obstacles that manager is aware of that could interfere with returning to work:			
Job specification (please attach a copy of the job description)			

Alterations/adaptations/reasonable adjustments that have already been made to assist the employee (please tick)

- ☐ Reduced hours ☐ Redeployment ☐ Redefined duties
- ☐ Use of special equipment ☐ Phased return
- ☐ Other: _____

To aid an early return to work, if relevant, please state what modified duties you or your member of staff think could be carried out:

Section F To be completed if referring for a musculoskeletal condition

Main issue/s:

Date of onset of symptoms:

Previous physiotherapy treatment for this condition?	Yes ☐	No ☐
Successful outcome of treatment?	Yes ☐	No ☐
Significant reduction in activities of daily living?	Yes ☐	No ☐
Sleep disturbance due to this condition?	Yes ☐	No ☐
Has a referral been made to another clinic/consultant for this condition? If yes please give details below.	Yes ☐	No ☐

Additional information:

Section G To be completed if referring for an emotional wellbeing or mental health condition		
Main issue/s including date of onset of symptoms:		
Formal diagnoses e.g. clinical depression, anxiety disorders such as PTSD, obsessive compulsive disorder. If yes please state:	Yes ☐	No ☐
Current symptoms e.g. Low mood	Yes ☐	No ☐
Poor motivation	Yes ☐	No ☐
Anger	Yes ☐	No ☐
Worry	Yes ☐	No ☐
Agitation	Yes ☐	No ☐
Feeling chronically stressed	Yes ☐	No ☐
Fatigued	Yes ☐	No ☐
Other please state:		
The following are based on the Health & Safety Executive's stress management standards and relate to workplace factors which if not proactively managed can impact on staff wellbeing.	Contributing to illness and/or absence	
Demands including issues like workload, work patterns and the work environment	Yes ☐	No ☐
Control i.e. how much say they have in the way they do their work	Yes ☐	No ☐
Support which includes resources provided by the organisation, line management and colleagues	Yes ☐	No ☐
Relationships which includes conflict and unacceptable behaviour	Yes ☐	No ☐
Role e.g. whether they understand their role within the organisation, whether they have conflicting roles	Yes ☐	No ☐
Change i.e. how workplace changes, large or small, are managed and communicated.	Yes ☐	No ☐
If you answered yes to any of the 6 areas identified above please give details of what has already been put into place to support the member of staff:		

Section H Advice Required (please tick)	
☐	Is the person fit to return to normal unrestricted duties of work?
☐	Is the person fit to return to modified duties of work?
☐	If modifications are required are they temporary or permanent? Please state time scale if temporary.
☐	Does the person need to be relocated to a different post? If yes, are there any specific recommendations about this?
☐	If none of these – is early retirement on grounds of ill health appropriate?
☐	Is the condition likely to be covered by the Equality Act 2010?
☐	Other advice required (please specify):

Section I Confirmation that the member of staff understands reason for referral.
<i>This section must be signed by the employee and only in EXCEPTIONAL circumstances will a referral form be accepted unsigned. Failure to sign this section may result in the referral form being returned and any appointment or assessment delayed.</i> I consent to being assessed in the Occupational Health Department and I have read and had the reason for this explained to me. I understand that any medical details discussed will remain confidential, and that my manager will only be informed of facts that relate to my employment and ability to work. I also understand that following the appointment Occupational Health will request my consent to send a report to my manager with a copy to my GP. The proposed contents of the report will be discussed with me in advance and I will be provided with a copy of the report for my own information as a matter of good practice. Should it be necessary for the Occupational Health Department to obtain a medical report from my GP or specialist I understand that this will only be done with my written permission. <i>If you are in doubt about why you are being asked to attend you should discuss this further with your manager before signing below.</i> Signed: Date: ____/____/____ Member of staff Signed: Date: ____/____/____ Referring Manager Further guidance is available from Occupational Health on telephone numbers: St Woolos 01633 238349 Nevill Hall 01873 732849 Ysbyty Ystrad Fawr 01443 802442

Occupational Health Use Only:

Appointment with: ☐ Consultant _____
☐ Doctor _____
☐ Senior OH Nurse advisor _____
☐ OH Nurse advisor _____

Method: ☐ Telephone ☐ Face to face appointment
Appointment duration: ☐ 30 min ☐ 40 min ☐ 60min
Priority: ☐ Urgent ☐ Routine

Additional information: _____

Action determined by: Name _____ Signature _____