

REQUEST FOR HEALTH / SICKNESS ABSENCE ASSESSMENT FORM FOR OCCUPATIONAL HEALTH AND WELLBEING

EMPLOYEE SIGNATORY:

I confirm that I understand the reasons why occupational health advice is being sought and understand it is a requirement to have a consultation.

Signed:

Print Name:

Date:

If it is not possible to obtain a signatory for the referral: I hereby confirm the employee understands the reasons why occupational health advice is sought and they understand it is a requirement to have a consultation.

PERSONAL DETAILS OF EMPLOYEE

Title:

DOB:

Surname:

First Name:

Job Title:

Home Tel No:

Mobile No:

Work No:

National Insurance No:

Employee Home Address:

Postcode:

EMPLOYMENT DETAILS

Employing Department:

Work Location:

Contact No:

Name of Manager for Correspondence:

Job Title:

CPG / Corporate Service:

Further job analysis may be requested as necessary.

Postal Address of Correspondent:

E-mail Address:

Human Resources Contact ***(if appropriate)***:

SICKNESS ABSENCE / HEALTH REQUEST DETAILS

Reason for referral ***(please state which reason by stating yes, no or not applicable)***

Off work long term – date commenced:

Short term frequent absence:
Condition affecting work fitness:
Other, specify:

Please provide details of the employee's absences for the past twelve months.

From	To	Total No. of Days lost	Cause of Absence
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(Please provide further details or details of any other significant absence prior to the last twelve months if necessary)

Are there any outstanding employment matters in relation to the employment that need to be identified and / or discussed in relation to health? Please give details:

MODIFIED DUTIES

Have or could any alterations or adaptations been made to the job to assist the employee?
If so please give details:

ADDITIONAL INFORMATION

Please use this space to provide further relevant information e.g. relating to the individuals domestics / work situation or to request specific information from the Occupational Health Practitioner.

REPORT CRITERIA

The Occupational health practitioner will normally provide advice on the following:

- Current state of fitness to work
- Any work adjustments
- Prognosis
- Timescale for the employee to recover/return to work
- Add any other specific questions you would like answering (see additional organisational guidance notes as locally developed)

MANAGER SIGNATORY:

Print name:

Date:

Signature (for paper referrals):

OCCUPATIONAL HEALTH USE ONLY:

Date received: / /

Appointment type:

Nurse Doctor

Assigned practitioner

Method:

Phone

Appointment

Domiciliary

3rd party report

Duration of appointment:

Priority:

Urgent

Routine

Consultation type:

Long term absence

Short term absence

Work fitness

Ill health retirement

Other support services

Other, specify

Additional Information:

Date:

Signature:

Date of consultation:

Reason for delay: