

OCCUPATIONAL HEALTH & WELLBEING DEPARTMENT

MANAGER REFERRAL FORM

| EMPLOYEE DETAILS | | | | | | |
|--|---|--------------------|-----------------|----------|-------|--------|
| Please ensure the contact details below are accurate and match those held on ESR. <i>Correspondence will be sent to the address held on ESR and cannot be entered manually by OH.</i> | | | | | | |
| Title | Mr | Mrs | Miss | Ms | Dr | Other: |
| Employee's full name | | | | | | |
| Date of birth | | | | | | |
| Home address | | | | | | |
| Contact no. (s) | Mobile: Work (if in work): | | Home: Other: | | | |
| | Please tick if the employee: | | | | | |
| | 1) does not wish to receive SMS text appointment reminders <input type="checkbox"/> | | | | | |
| | 2) does not wish to receive telephone answer phone messages from OH <input type="checkbox"/> | | | | | |
| Known unavailability? | | | | | | |
| Preferred method of contact: | <i>If relevant, please provide employee's <u>work</u> email/telephone.</i> | | | | | |
| GP Name & Address: | | | | | | |
| Work address (base) | | | | | | |
| Job title | | | | | | |
| Time in post | | | | | | |
| Contracted hours | | Work pattern/days | | | | |
| Registered disabled? | Yes / No | In work currently? | | Yes / No | | |
| Details of previous redeployment? | | | | | | |
| Please confirm you have discussed this referral with the employee: | | | | | (Y/N) | |

| REFERRAL REASON | | |
|---|-------------------------------|------------------------------|
| Please circle if you referral is related to: | | |
| Domestic abuse | Work-related stress | Violence & aggression |
| Bullying & harassment | Capability | Suspension |
| Investigation | Ill-health retirement request | Workplace assessment request |
| Infectious notifiable disease | Planned absence | Pregnancy related |
| Work related injury | Long term sickness | Short term sickness <28 days |
| Work retention advice | Other | |
| If this was a work related accident/incident, was this reported under RIDDOR? | | Yes No |

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| Please give a brief description of the health problem/situation: | |
| Details of any health investigations/intervention taking place or planned: | |
| How long has the problem/symptoms/situation been present: <div style="display: flex; justify-content: space-around;"> <24 hours ____ 1-7 days ____ 1-3 weeks ____ </div> <div style="display: flex; justify-content: space-around;"> 3-8 weeks ____ 2-6 months ____ >6 months ____ </div> | |
| ABSENCE DETAILS (If relevant) | |
| Start date of absence: | |
| Fit note length: | |
| Fit note diagnosis: | |
| Fit note recommendations: (Please tick) | <div style="display: flex; justify-content: space-between;"> Phased Return <input type="checkbox"/> Amended duties <input type="checkbox"/> </div> <div style="display: flex; justify-content: space-between;"> Altered Hours <input type="checkbox"/> Workplace adaptations <input type="checkbox"/> </div> |
| Any further advice from GP on fit note: | |

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| JOB RELATED MATTERS: |
| Please list the employees main work-related tasks: |
| Has any relevant risk assessment been completed? Please provide details: |
| Have any plans/adjustments been put in place to facilitate a return to work/remain in work? |
| Any further relevant information or work related concerns: |

| PREVIOUS ABSENCES (18 months) | |
|-------------------------------|--------|
| DATE | REASON |
| | |
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| OPINION SOUGHT FROM OCCUPATIONAL HEALTH: | Please tick information required: |
|---|-----------------------------------|
| If currently off sick, an indication of the earliest return to work (RTW) date and predicted length of absence. | |
| Advice relating to frequent short term absence: Common underlying causes, likelihood of overall improvement and timescale. | |
| Identification of any underlying medical condition and details around its likely length. | |

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| Impact of problem/condition on work role and effective work attendance in the future. | |
| Impact of work on their health condition. | |
| Consideration of redeployment suitability. | |
| Recommendations of adjustments/limitations/alternative duties. | |
| Suggestion of a more suitable role. | |
| Advice on any medication that would affect their ability to carry out their duties. | |
| Would time off be required to attend health appointments. | |
| Advice on a phased return/rehabilitation programme. | |
| Considerations of implications in relation to the Equality Act 2010 and advice on any reasonable adjustments to the job or working conditions. | |
| Consideration of ill-health retirement. | |
| Work place assessment. | |
| Other: <i>Please outline any additional questions/requests clearly below.</i> | |

| REFERRING MANAGER DETAILS | | | |
|---------------------------|--|---------------|--|
| Name | | Referral date | |
| Department | | | |
| Work address | | | |
| Contact no. | | | |
| Work email | | | |

| Notes for Line Manager: |
|---|
| Emergency / Risk Situations Please note, the OH service is not an emergency service. For immediate risks or concerns around an employee's health & wellbeing, please contact either: A&E / Crisis Team / Employee's GP / Police. |
| Change in Line Manager Should the line manager change during the referral process it is your duty to notify OH of the new line manager. Consent will be sought from the employee prior to any OH report being shared. |
| Appointment Notification The referral will be triaged within 1 working day, following allocation of an appointment both employee and line manager will be notified accordingly. |
| Referral Triage Please provide as much information as possible on the referral. The triage procedure will assess whom the employee sees, where the appointment takes place and within what timescale. Please refrain from requesting a specific clinician. |
| Occupational Health Report The Occupational Health Case Manager will aim to supply as much factual information as possible without breaching staff confidentiality. Consent will be sought from the employee at the time of the appointment. The report will be emailed to you in line with the employee's consent. |
| Future Appointments The date of any further planned review within the OH department will be indicated at the end of the report. If no report is required or consented to, you will be notified via a separate email. |
| Non Attendance (DNA) If the employee fails to attend the allocated appointment, you will be notified via email and 1 further appointment will be provided unless you advise otherwise. |
| Planned sickness absence For planned absences such as surgery, please complete the Planned Absence Form (within the HR Sickness Toolkit) with the employee, prior to their absence. Please discuss with them the expected recovery period so that an OH referral can be made within an appropriate timescale. |

PLEASE RETURN THIS FORM TO:

By post: OCCUPATIONAL HEALTH & WELLBEING DEPARTMENT
DEWI SANT HOSPITAL
ALBERT ROAD
PONTYPRIDD
CF37 1LB

By PII email: CTT_Occupationalhealth@wales.nhs.uk

Incomplete forms will not be processed and will be returned to you for re-completion.

For Occupational Health Use Only

Date received in OH:

Received by:

Triaged by:

Date:

Allocated to:

Priority:

Other Comments: