**Management Referral to Occupational Health**

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| **Employee’s Name:** | |  | | | | |
| **Home Address:** | |  | | | | |
| **Date of Birth:** | |  | | | | |
| **Telephone – Home:** | | **Telephone – Work:** | | | | |
| **Work Location:** | | **Employee’s Job Role:** | | | | |
| **School / Directorate:** | |  | | | | |
|  | |  | | | | |
| **Please provide details of sickness absence:** | | | | | | |
|  | | | | | | |
| **Period Reason Impact** | | | | | | |
| Within last month |  | | Days or Instances | | |  |
| Within last 3 months |  | | Days or Instances | | |  |
| Within last 12 months |  | | Days or Instances | | |  |
| **1st Date of Absence:** | **Anticipated Return to Work Date:** | | **Date Med. Cert. Expires:** | | |  |
|  |  | |  | | |  |
| The referral to Occupational Health should always be discussed with the employee first in line with Brookes Attendance Management Policy | | | | | | |
|  | | | | **Yes** | **No** | |
| Date that employee was informed of referral: | | | | | | |

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| --- | --- | --- | --- |
| Full Time (please √ ) |  | Part Time (please √ ) |  |
| Number of contracted hours per week: | | | |
|  | | | |
| **Please describe principal duties of post**  **(or attach current job description - if attached please** √**)** | | | |  |

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| --- | --- | --- | --- |
| **Reason for Referral (please √ as appropriate):** | | |  |
| Long term sickness absence |  | Recurrent short term sickness absence |  |
| Ill health retirement assessment |  | Concerns for work performance/fitness for work |  |
| Substance abuse problems (alcohol or drugs) |  | Occupational exposure hazard concerns |  |
| Investigation of workplace illness or injury |  |  |  |
| Other: | | | |

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| **Please describe nature of problem which has initiated referral:** |
| (Use separate sheet if required) |

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| **Specific Advice from Occupational Health (please √ as appropriate):** | | |  |
| Is the employee fit for work? |  | When will the employee become fit to work? | | |  |
| Is the medical problem likely to be caused or made worse by work activity? |  | Are job restrictions or modifications required/ appropriate? | | |  |
| Is the Disability Discrimination Act 1995 likely to apply? |  | Is the employee likely to have further absences due to this illness? | | |  |
| Does the employee meet Brookes Ill-Health Retirement Criteria? | | | | |  |

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| **Other questions:** |

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| **Name of Manager Making Referral:** |
| **Tel. Contact Number:** |
| **School / Directorate:** |
| **Date of Referral:** |
| **Name of HR Business Partner:** |
| **Name of HR Manager:** |
| **Name of HR Link Manager (School/Directorate, if appropriate):** |