**Management Referral to Occupational Health**

| **Employee’s Name:** |  |
| --- | --- |
| **P Number:** |  |
| **Home Address:** |  |
| **Telephone – Home:** |  **Telephone – Work:** |
| **Work Location:** |  **Employee’s Job Role:**  |
| **Faculty / 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:**

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

| **Name of Manager Making Referral:** |
| --- |
| **Tel. Contact Number:** |
| **Faculty / Directorate:** |
| **Date of Referral:** |
| **Name of Strategic People Partner:** |
| **Name of People Manager:** |
| **Name of Link People Manager (Faculty/Directorate, if appropriate):** |