**CUH MANAGEMENT REFERRAL FORM**

Please complete this form as comprehensively as possible

**Send as an attachment to [cuh.hr.consult@nhs.net](mailto:cuh.hr.consult@nhs.net) once completed**

**Section 1: Employee Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **First Name** |  | | **Surname** |  |
| **Known as** |  | | **DOB** |  |
| **Preferred Pronouns** |  | | **NHS Number** |  |
| **Job Title** |  | | | |
| **Department & Box Number** |  | | **Work Extension Number** |  |
| **Can the employee attend an appointment at short notice?** | | | | No 🞎 Yes 🞎 |
| **Are there any times or days to avoid? Please include annual leave if applicable** | | |  | |
| **Home Number** |  | | **Mobile Number** |  |
| **Can a message be left on:** | Home Phone: Yes 🞎  Mobile Phone: Yes 🞎 | | Please tick this box if a message **cannot** be left 🞎 | |
| **Home Address (required for appointment letter)** | | |  | |
| **Work Email Address** | |  | | |

**Section 2: Referrer Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** | |  | |
| **Job Title** | |  | |
| **Department & Box Number** | |  | |
| **Division/Corporate Area** | |  | |
| **Extension Number** | |  | |
| **Email Address** | |  | |
| **HR Contact** | |  | |
| **HR Email Address** | |  | |
| Please confirm the employee has been informed of this referral and provided with a copy and that all details given in this form were discussed with the employee on:    🞎 by phone 🞎 letter 🞎 at a meeting  I have discussed this referral with my HR contact 🞎 Yes 🞎 No  If completing this form electronically enter your name and dates in the fields below and then check the following box to indicate that you confirm the information given in this form  🞎 | | | |
| **Date** |  | **Signature** |  |

All information will be treated in the strictest confidence. Following a consultation with oh *Occupational Health and Wellbeing*, the employee will be asked to consent to a report based on the consultation and the information you have provided. oh, *Occupational Health and Wellbeing* may recommend a case conference between the Occupational Health Clinician, HR and Line Manager to discuss how best to support the employee.

**Section 3: About the Role**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Length of time in current role & start date if known** | | |  | |
| **Total number of years worked at the Trust** | | |  | |
| **Does the employee hold another post in the Trust?** | | | No 🞎 Yes 🞎 (if yes, please specify below) | |
| **NB. If the employee holds another post in the Trust, please discuss with HR whether this referral will affect the other job/bank work. Occupational health will only respond to the referring manager.** | | | | |
|  | | | | |
| **Work Pattern** | **The individual’s normal hours of work are:**  🞎 Shift work 🞎 Night worker 🞎 Rotating shifts 🞎 Normal office hours  **Contracted Hours:** (00:00) - (00:00) | | | |
| **Please indicate the hazards that affect this role** | | | | |
| * Driving for work * Working in isolation/lone work * Working at heights * Food handling/preparation * DSE user * Manual handling * Work with respiratory sensitisers/ Irritants (including latex) * Work with to skin sensitisers /irritants * Exposure tonoise | | * Work with heavy/toxic metals * Work in a containment facility(category 2/3) * Working in confined spaces * Fork Lift Truck * Group 2 Driving e.g PCV * Work with novel compounds or carcinogens * Work with ionising radiation requiring classification * Working with vibrating tools (HAVS) * Night work | | * Working with biological agents, human tissue and/or blood * Contact with patients in a clinical environment * Undertaking Exposure Prone Procedures * Other (please specify)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     * **No Hazards Apply** |

**Section 4: Attendance Record This section must be completed please**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **How many days has the employee been absent in the past 6 months?** | | |  | days |
| **On how many occasions has the employee been absent in the past six months?** | | |  | occasions |
| **Current work status:** | 🞎 At work | 🞎 On sick leave (please give details below) | | |
| **Reason for current absence: (please attach any sickness absence/stress risk assessment records that may be relevant) Please provide as much information as possible so we can effectively triage.** | | | | |
|  | | | | |

|  |  |
| --- | --- |
| **When did the current sickness commence? (dd/mm/yy)** |  |
| **Is the employee being managed under any sickness absence procedure and which stage has this reached? (please specify)** | |
|  | |
| **Are there any documented concerns about the employee’s job performance? (please specify)** | |
|  | |

**Section 5: About this Referral Both parts of this section must be completed please, otherwise the referral will be returned for completion**

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| **My main concern is…** |
|  |
| **The main reasons for this referral include (please give a primary reason, and secondary if applicable, clearly high-lighting which is primary)** |
| 1. 🞎 Prolonged period of sickness absence 2. 🞎 Frequent short-term sickness absence 3. 🞎 Stress impacting on work performance / health 4. 🞎 Health condition (physical and/or mental) impacting on work performance / health / attendance 5. 🞎 Injury at work (please ensure QSIS completed) 6. 🞎 Performance concerns 7. 🞎 Fitness to attend meetings (e.g. disciplinary / performance / attendance) 8. 🞎 Physiotherapy (patient will need to complete physio self-referral form please) 9. 🞎 Other, please specify |
| **The aspects of the employee’s health I would like oh Occupational Health and Wellbeing to address in their assessment include** |
| 1. 🞎 Are there any underlying health conditions? 2. 🞎 Do any of these health conditions affect the employee’s attendance/performance? 3. 🞎 Is the condition work-related? 4. 🞎 If the employee is not currently able to return to work, when are they likely to be able to return to work? 5. 🞎 When the employee returns, will any restrictions or alterations be required to their duties? 6. 🞎 Will any restrictions or alterations be temporary or permanent? 7. 🞎 Would an application for early retirement on the grounds of ill health be appropriate? 8. 🞎 Should alternative employment be considered? 9. 🞎 If this person is unlikely to able to return in the foreseeable future, would they be eligible for early retirement on the grounds of ill-health? |

|  |  |
| --- | --- |
| **Are there any additional questions you would like to ask?** | |
|  | |
| **Is there any further information that may be helpful in supporting the employee’s health at work?** | |
|  | |
| **If appropriate, what reduced hours and/or restricted duties could your service support?** | |
|  | |
| **If appropriate, has a Stress Risk Assessment been completed?** | 🞎 Yes (please submit with referral) 🞎 No 🞎 N/A |
| **If appropriate, has a New and Expectant Mothers Risk Assessment been completed?** | 🞎 Yes (please submit with referral) 🞎 No 🞎 N/A |