**CUH MANAGEMENT REFERRAL FORM**

Please complete this form as comprehensively as possible

**Send as an attachment to 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 meetingI 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)

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**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?
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|  |
| --- |
| **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 |