**COVID RISK ASSESSMENT REFERRAL FORM**

Please complete this form as comprehensively as possible

**Send as an attachment to** **add-tr.ohhelpline@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 meetingIf 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 new management referral be completed if required and may also 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) |

**Section 4: About this Covid Risk Assessment Referral. Both parts of this section must be completed please, otherwise the referral will be returned for completion**

|  |  |
| --- | --- |
| **Current Covid Risk Assessment Group:** |  |
| **Previous Risk Assessment Groups****(Reason for change)** |  |
| **Has the individual previously shielded during the pandemic or changed departments for their safety & why (redeployment)?** |  |
| **Employee/ managers main concern is…**  |
|  |
| **The main reasons for this Covid risk assessment referral include (please give a primary reason, and secondary if applicable, clearly high-lighting which is primary)** |
| 1. 🞎 change in risk assessment group
2. 🞎 change in working environment/ redeployment
3. 🞎 Anxiety & concerns regarding change in previous restrictions due to updated guidance
4. 🞎 change in health that may impact job role
5. 🞎 change in health/new diagnosis
6. 🞎 change in immunosuppressant medications
7. 🞎 Do any of these health conditions affect the employee’s attendance/performance?
8. 🞎 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 recommendation to keep my employee safe?
2. 🞎 Should alternative employment be considered?
3. 🞎 Are there any specific restrictions needed in their current role?
4. 🞎 Will any restrictions or alterations be temporary or permanent?

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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 |