**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** |  | | **Date Of Birth** |  |
| **Preferred Pronouns** |  | | **NHS Number (if known)** |  |
| **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** | |  | | |
| **Does the individual require a specific gender clinician for their appointment?** | |  | | |
| **Does the individual have any accessibility needs?** | | No  Yes **If yes, detail accessibility requirements** | | |

**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** |  |

**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**

|  |  |  |  |
| --- | --- | --- | --- |
| **Current work status:** | At work (please proceed to Section 5) | On sick leave (please give details below) |  |
| **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 |
| **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 the Referral Both parts of this section must be completed please, otherwise the referral will be returned for completion**

|  |  |
| --- | --- |
| **My main concern is…** | |
|  | |
| **The main occupational referral reason for this referral include (please tick primary reason only)** | |
| 1. Fitness to attend meetings 2. Frequent short-term sickness absence 3. Health condition impacting on work/health etc 4. Illness 5. Injury at work (ensure QSIS completed) 6. Long term sickness absence 7. Performance concerns 8. Prolonged periods of sickness absence 9. Return to work 10. Stress impacting on work/health (submit stress risk assessment with referral) 11. Physiotherapy (patient will need to complete physio self-referral form) 12. Other, please specify | |
| **The main health reason for referral (to correspond with health roster, please tick primary reason only)** | |
| Anxiety/stress/depression/psychiatric illness  Blood disorders  Heart, circulatory (inc BP, stroke)  Burns, poisoning, frostbite, hypothermia  Ears, Nose and Throat  Dental & oral (inc toothache)  Eye problems  Endocrine/glandular  Gastrointestinal (inc tummy, stomach)  Diarrhoea/vomiting (one or both)  Allergic reaction at work  Influenza  Cold, Cough, viral (inc raised temperature)  Headache/Migraine | Genito-urinary (inc kidney)  Back problems  Musculoskeletal (all except back)  Gynaecological  Infectious diseases  Injury, fracture (any fracture, any injury)  Nervous system disorders (inc fits, brain issues)  Pregnancy related  Skin disorders  Substance abuse  Asthma  Chest & respiratory problems  Cancer Benign & malignant tumours |
| **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. In your opinion, is the employee likely to be considered disabled under the Equality Act 2010? | |

|  |  |
| --- | --- |
| **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 stress has been indicated in Section 5, please complete a Stress Risk Assessment** | Yes (please submit with referral)  No  N/A |
| **If pregnancy has been indicated, please complete a New and Expectant Mothers Risk Assessment** | Yes (please submit with referral)  No  N/A |