**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** |  | **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 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** |  |

**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**

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| **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?
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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 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 |