**MANAGEMENT REFERRAL GUIDANCE TEMPLATE**

**PLEASE NOTE: This template can be printed off to assist you only. However, we WILL NOT accept this form as an employee’s final OH referral as it must be submitted via the electronic link above**.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EMPLOYEE AWARE?** | | | | | | | | | | | | | | |
| **Managers, please note before you proceed with this referral: The content of the referral you are about to submit and reason for referral to Occupational Health MUST be discussed and explained to the employee.**  **Please confirmthat you have done this by placing a X in the following box…**  **This referral will form part of the medical record and can be viewed by an employee under Data Protection Legislation** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **DETAILS OF REFERRING MANAGER / ORGANISATION** | | | | | | | | | | | | | | |
| **Cost Code: Referrals CANNOT be accepted without this information** | | | | | | | | |  | | | | | |
| **Name Of Organisation:** | | |  | | | | | | | | | | | |
| **Name of Manager** | | |  | | | | | | | | | | | |
| **Email:** | | |  | | | | | | | | | | | |
| **Contact Number:** | | |  | | | | | | | | | | | |
| **HR Team/Officer:** | | |  | | | | | | | | | | | |
| **Additional Manager (If required)** | | | | | | | | | | | | | | |
| **Name** | | |  | | | | | | | | | | | |
| **Email** | | |  | | | | | | | | | | | |
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| **EMPLOYEE DETAILS** | | | | | | | | | | | | | | |
| **Employee Number** | | | | | **Date of Birth** | | | **Job Title** | | | | | | |
|  | | | | |  | | |  | | | | | | |
| **Title** | | | | | **First Name(s)** | | | **Surname** | | | | | | |
|  | | | | |  | | |  | | | | | | |
| **Personal Telephone Number(s)** | | | | | **Home Address** | | | **Department** | | | | | | |
|  | | | | |  | | |  | | | | | | |
| **Employee Email** | | | | | | **How does the employee wish to be contacted**  **Place an X in the appropriate box:** | | | | | | | | |
|  | | | | | | **Post** | |  | | **Email** | | |  | |
| **Work base** | | | | | **Service** | | | **Division** | | | | | | |
|  | | | | |  | | |  | | | | | | |
| **Additional post (Please specify)** | | | | |  | | | | | | | | | |
| **ABSENCE HISTORY** | | | | | | | | | | | | | | |
| **Is the employee currently off work as a result of sickness?**  **(Yes/No)** | | | | | | |  | | | | | | | |
| IMPORTANTPlease give details of previous absence history including dates, durations and reasons for the previous 12 months (continue on separate sheet if necessary) | | | | | | | | | | | | | | |
| **Date:** | | **Duration** | | **Reason:** | | | | | | | | | | |
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| REASON FOR REFERRAL | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| * **Occupational Health Advisor / Physician** | | | | | | | | | | | | | | |
|  | ***Please proceed by filling in the remaining sections below. The more information you provide the more accurate and detailed the Medical Report will be. You can give relevant supplementary information by using the free text box on Page 3 below to fully explain your concerns:*** | | | | | | | | | | | | | |
| **WHICH QUESTIONS WOULD YOU LIKE ANSWERED IN THE OH PHYSICIAN’S / ADVISOR’S MEDICAL REPORT?** | | | | | | | | | | | | | | |
| Is the employee fit to undertake his / her current post / job at present? *(If you would like this question answered you* ***MUST*** *ensure you fill in the working activities table on the page overleaf)* | | | | | | | | | | | | | |  | |
| Is the reason for ill health resolvable / permanent / intermittent / progressive? | | | | | | | | | | | | | |  | |
| Does the condition have a substantial adverse effect on normal day to day activity? | | | | | | | | | | | | | |  | |
| Are the Disability Discrimination provisions of the Equality Act 2010 likely to apply in this case? | | | | | | | | | | | | | |  | |
| Is there evidence to indicate that the employee’s current health problem may be work related? | | | | | | | | | | | | | |  | |
| Are there any adjustments/restrictions required? What is the expected duration of these? | | | | | | | | | | | | | |  | |
| Is it possible to indicate a potential return to work date? | | | | | | | | | | | | | |  | |
| **Please expand on the reason for your referral below.**  Any background information regarding the employee’s current sickness absence or medical condition will aid the Occupational Health Physician / Adviser in assessing their case: | | | | | | | | | | | | | | |
| **Background**  **Adjustments** | | | | | | | | | | | | | | |
| **WORKING ACTIVITIES UNDERTAKEN BY EMPLOYEE** | | | | | | | | | | | | | | |
| Please indicate in the table below with a ***X***all of the working activities that your employee is required to undertake on a daily basis as part of their job role. | | | | | | | | | | | | | | |
| **Working Activities** | | | | | | | **Frequently** | | | | **Sometimes** | **Never** | | |
| Standing | | | | | | |  | | | |  |  | | |
| Walking | | | | | | |  | | | |  |  | | |
| Prolonged Sitting | | | | | | |  | | | |  |  | | |
| DSE / Computer Work | | | | | | |  | | | |  |  | | |
| Manual Handling | | | | | | |  | | | |  |  | | |
| Driving | | | | | | |  | | | |  |  | | |
| Night Working | | | | | | |  | | | |  |  | | |
| Working at Height / Climbing Ladders | | | | | | |  | | | |  |  | | |
| Working with Dangerous Machinery | | | | | | |  | | | |  |  | | |
| Working with Chemicals | | | | | | |  | | | |  |  | | |
| Working with Biological Agents | | | | | | |  | | | |  |  | | |
| Working with Skin Irritants / Sensitisers | | | | | | |  | | | |  |  | | |
| Working with Respiratory Irritants / Sensitisers | | | | | | |  | | | |  |  | | |
| Working with Dust or Fumes | | | | | | |  | | | |  |  | | |
| Working with Machinery that Vibrates the Hands, Arms or Body | | | | | | |  | | | |  |  | | |
| Lifting / Carrying - ***Max Weight***: | | | | | | |  | | | |  |  | | |
| Working in Confined Spaces | | | | | | |  | | | |  |  | | |
| High Pressure / Demanding Role | | | | | | |  | | | |  |  | | |
| Working with Vulnerable Adults / Children | | | | | | |  | | | |  |  | | |
| Lone Working | | | | | | |  | | | |  |  | | |
| Other Working Activities which you consider to be relevant – Please Specify: | | | | | | | | | | | | | | |
| **This referral will form part of the medical record and can be viewed by an employee under Data Protection Legislation** | | | | | | | | | | | | | | |

*Please return this form to HR via* [*humanresources@ceredigion.gov.uk*](mailto:humanresources@ceredigion.gov.uk)