



The Occupational Health Team Ltd

OCCUPATIONAL HEALTH REFERRAL

REFERRING MANAGER			
Name:		Company:	
Position:		Tel No:	
e-mail:			

EMPLOYEE DETAILS			
Name:		Tel No:	
Address:			
Position:		Time in current post:	

Section 1 - REASON FOR REFERRAL TO OCCUPATIONAL HEALTH		
(Tick one box)		
The employee is currently on Long Term Sickness Absence. (Complete the absence history below)		
Frequent short term sickness (Complete the absence history below)		
DETAILS		
Date of sickness (from – to)	No. of days	Reason for absence
Concern about the employee's health and ability to carry out their duties. (Provide details below)		
The employee has had a work related accident or injury. (Provide details below)		
The rehabilitation plan is not progressing as planned. (Provide details below)		
Other (Provide details below)		
DETAILS * Please give as much detail as possible to assist OH with the assessment		

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SECTION 2 – JOB DETAILS			
Job Title:		Shift Pattern:	
Hours worked per week:		Job Description Attached: Y / N	
The following descriptors apply to this employees work(put an X to all those that apply)			
Office	<input type="checkbox"/>	Supervisory	<input type="checkbox"/>
Non-Clinical	<input type="checkbox"/>	Laboratory	<input type="checkbox"/>
Shift work	<input type="checkbox"/>	Full time	<input type="checkbox"/>
Emotionally demanding	<input type="checkbox"/>	Physically demanding	<input type="checkbox"/>
VDU Use	<input type="checkbox"/>	Driving	<input type="checkbox"/>
		Clinical	<input type="checkbox"/>
		Lone work	<input type="checkbox"/>
		Part time	<input type="checkbox"/>
		Manual Handling	<input type="checkbox"/>
		Outside work	<input type="checkbox"/>

SECTION 3 – FORMAL RESPONSE REQUESTED FROM OCCUPATIONAL HEALTH	
Mark all the questions that are relevant to this case and that you would like OH to answer:	
What is the employee's current state of health?	<input type="checkbox"/>
When is it likely that the employee will be fit to return to work?	<input type="checkbox"/>
Is the employee fit to carry out their current duties?	<input type="checkbox"/>
Is there any additional help or treatment that might assist the employee returning to/or remaining at work?	<input type="checkbox"/>
What adjustments are required to enable the employee to return to/or remain at work?	<input type="checkbox"/>
Is there any underlying medical condition causing or contributing to the employee's attendance or performance record?	<input type="checkbox"/>
Is it likely that the employee will be able to give reliable and consistent attendance in the future?	<input type="checkbox"/>
Any other information required? Please continue on separate sheet where required.	<input type="checkbox"/>

SECTION 4 – TO BE COMPLETED BY THE REFERRING MANAGER IN ALL CASES	
I can confirm that I have discussed the reason for this referral to Occupational Health with the employee and they have indicated that they have understood the reason for the referral and recognise that a written report from Occupational Health will be sent to the Referring Manager following their appointment.	
Manager's Name:	Date discussed: