Midrand

Management Referral to Occupational Health
CONFIDENTIAL

Please ensure this form is completed fully to assist the Occupational Health Advisor / Physician in providing you with a comprehensive report.
It is important that the employee understands why they are being referred.
To make an appointment please complete this and send it to Occupational Health.

Referring Manager Details	
Name:	Company:
Tel. No:	Address:
Fax. No:	
E-mail:	
Position:	
Employee Details	
Name:	
Home Address:	
Date of Birth:	
Job Title:	
Department:	
Location of Post / Site:	
Full Time or Part Time?	
Length of time in current position: Started:	
Home Telephone:	
Daytime Telephone:	
Sickness Print included	Yes / No
Are there any specific requirements needed to assist in this assessment (i.e. interpreter, advocate) **Yes / No : If yes please specify :**	
Please describe duties of the position (or attach copy of job description)	
Job Description as follows	

Reason for Referral (Please ✓ as appropriate)			
Long term sickness absence		Recurrent short term sickness absence	
Ill health retirement assessment		Concerns for work performance	

Workplace assessment		Health surveillance	
Occupational exposure hazard concerns		Investigation of workplace illness or injury	
Substance Abuse problems			

Other (Please specify)

Please provide details of current problem (How is this affecting their ability to work?)

Before close of appointment can Occupational Health please request signed consent from the staff member confirming agreement and support regarding this appointment either by signing the bottom of this form or on a separate form provided by Occupational Health (documentation relating to this can be found in Occ.Health folder).

How long has the problem been present?	

What remedial action have you taken?

What specific questions do you want answered?

(Please tick the questions you wish to ask or delete questions that do not apply to this referral)

1. **Is the medical problem caused or made worse by work?**
2. **Is the employee fit to perform their current duties?**
3. **Is the employee's medical condition currently or in future likely to fall under the Disability Discrimination Act (DDA)**
4. **Is there an Underlying Condition?**
5. **Does the employee require any modification to his work? If so please specify required modifications and for how long?**
6. **Will further medical information be required prior to outcome of the assessment?**
7. **Please indicate if you know when this employee is likely to return to work date?**
8. **Will a review appointment with OHS be required? If so please state the date.**
9. **Will a phased return be necessary for this employee? If so please specify the return to work programme.**
10. **Prognosis of regular attendance in the future.**

I confirm that the reason for referral has been fully explained to the employee.
Referring Manager

Signature:

Name: Date:

Employee signature (where possible)
I confirm that the referral has been fully explained to me.

Signed: Date: