**MANAGEMENT REFERRAL FORM**

**Personal Information**

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| --- | --- | --- | --- |
| **Name:** | | | **Date of Birth:** |
| **Home Address:** | | | |
| **Home Tel:** | | **Mobile Tel:** | **Work Tel:** |
| **Company:** | | | |
| **Job Title:** | **Underwriter** | | |

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| **Please tick those for which information is required. The Doctor/Adviser will address each of the areas indicated.**  **☐ Assessment of medical capability to continue in present role**  **☐ Review/update regarding on-going health issues and impact on work**  **☐ Recommendations on any adjustments in the workplace**  **☐ Advice regarding the Equality Act 2010** |
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**Absence Details** If the referral is related to absence please provide the following information

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| --- | --- | --- |
| **Is the employee currently absent from work? No(Please indicate as appropriate)** | | |
| **First date of absence:** | **Last date of absence:** | |
| **Information relating to referral:** *please give brief reasons for the referral and reference any information pertinent to the employee’s medical or domestic situation or absence history that has already been made known to you.* | |
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| **What action has already been taken to support the employee?** | |
| **Please write any specific questions regarding the employee here.**   1. **Is there an underlying medical reason for this absence?**   Answer:   1. **Is the individual receiving / has received adequate support from the Company for their underlying condition?**   Answer:   1. **Is the individual medically fit / capable of managing their normal role / duties? (If no, what are their capabilities?)**   Answer:   1. **What accommodations / adjustments (adaptations, modifications or reasonable adjustments) are recommended to facilitate a reduction in absence levels?**   Answer:   1. **Are these accommodations likely to be temporary or permanent? (If temporary, what are the timescales?)**   Answer:   1. **When will the above provisions need to be in place by?**   Answer:   1. **Is the condition likely to recur and (if applicable) is further absence likely?**   Answer:   1. **Is the co-worker medically fit and able to continue in their current role?**   Answer:   1. **Are you aware of any social, welfare or work issues affecting their attendance or performance?**   Answer:   1. **Is a further review by Occupational Health required? If so, approximately when? (Please specify if the individual is discharged, and why, or not).**   Answer: | |

**Persons Responsible for the Management of this Case**

* **I confirm that this referral has been fully discussed with the employee either directly via telephone or formal consultation and that they understand the reason for this referral: Form completed by referring manager:**

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| **Signed:** | **Date:** |
| **Name:** | **Position:**  HR Business Partner |
| **Contact Number:** | **E-Mail Address:** |

**Employee:**

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| --- | --- |
| **I confirm that this referral has been fully discussed with me and I consent to attending occupational health and that a report will be sent to my manager and HR.** | |
| **Signed:**  **See consent form** | **Date:** |

**Please forward this form via email to** [david@dbocchealth.com](mailto:david@dbocchealth.com) **Advice will not be given unless the referral has been discussed fully with the employee.**