**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 **Advice will not be given unless the referral has been discussed fully with the employee.**