**OCCUPATIONAL HEALTH ASSESSMENT (OHA) - REFFERRAL FORM**

**Including Section Specific to COVID-19 Query**

**Introduction – information for the referring Line Manager or approved designate**

1. **If your concern is relating to COVID-19 only Section A and Section B 1.1 to 1.3 (b) inclusive required.**
2. The Line Manager or approved designate will verbally or in written format advise the employee that they are being referred for an OHA and that a member of the HR department will be in touch with them shortly to provide appointment details.
3. The Line Manager or approved designate is required to **fully complete all** of the OHA referral form.
4. Once fully completed the Line Manager or approved designate should send the OHA referral form to the HR Officer for their region.

**Section A – Referring Line Manger or approved designate Information**

* 1. **– Details**

**Name of person making the OHA referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name & Address of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* 1. **– Checklist (please tick to indicate completion)**

**I have explained to the employee the reason for this referral**

**I enclose the employee’s current job description (please attached details of current duties)**

**Other relevant documents i.e. Copy of sick certificates/Absence**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Referring Line Manager or approved designate)

**Section B – Referral Information**

* 1. **– Employee Referral Information**

**Employee’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DD/MM/YY) Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Personal Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**General Practitioner (GP)/Treating Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* 1. **– Employee Job Details**

**Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Description: Attached**

**Name of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weekly Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Pattern: Full-Time Part-Time Job Share**

**Night Work: None Occasional Regular**

* 1. **- Current Medical Issues**

**Is the employee currently on sick leave? Yes No**

**What is the reason given for this absence? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1.3 (b)- COVID-19 Concern (only fill in if query specific to Covid -19)**

**What is your specific concern?**

**Does the employee feel they may be vulnerable and require clarification?**

**Has the employee developed a respiratory illness?**

**Has the employee contracted COVID-19?**

**Any history available**

**Is the employee self-isolating and is further guidance required**

**Please specify**

* 1. **– Summary Reason for OHA Referral**

**Why is the employee being referred for an OHA assessment at this time? Please tick all the appropriate boxes:**

**Return to work following sick absence**

**Concern over conduct (behavioural difficulties)**

**Concern over attendance**

**Concern over performance**

**Disability assessment**

**Safety issue**

**Assessment after incident at work**

**Fitness for re-deployment & rehabilitation due to ill health**

**Consideration for medical retirement**

**Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If the referral is in relation to frequent short term absence please attach copies of Return to Work Interview (RTWI) forms & details of Return to Work Meetings held: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* 1. **– Detailed Reason for OHA Referral**

**Describe the main issues chronologically which have initiated this request and detail any other relevant**

**facts while highlighting your actual concerns about this employee in relation to their duties:**

* 1. **– Specific Advice Required (what questions would you like answered)**

**Section C – Supplementary Attachments Referral Information**

**To assist the OHA Practitioner conduct a thorough assessment of the employee and their fitness for work please include the following attachments with this referral:**

* **A summary of the employees’ sick absence record for the previous 12 months**
* **Copies of medical certificates supporting the sick absence in the previous 12 months**
* **An up to date copy of the employee’s job description**

**Section D – Human Resources (HR) Officer**

**HR Officer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**