

OMT-003

EMPLOYER OCCUPATIONAL MEDICAL REFERRAL FORM

CONFIDENTIAL

For completion by the employer, manager or Human Resources representative before referral.

The purpose of this form is to provide sufficient occupational information to permit a meaningful assessment of the employee's health in relation to work. Please provide factual information and ask specific occupational questions. The Occupational Physician advises on health, function, fitness for work and possible accommodations. Management decisions remain the responsibility of the employer.

1. EMPLOYEE DETAILS

Employee name: _____

Date of birth: _____

Employer: _____

Job title: _____

Department / location: _____

Date employment commenced: _____

Date commenced current role: _____

Normal contracted hours per week: _____

Normal working pattern / shift pattern: _____

2. REFERRER DETAILS

Name: _____

Position: _____

Telephone: _____

Email: _____

Date of referral: _____

3. EMPLOYEE AWARENESS OF REFERRAL

Has the employee been informed of this referral?

☐ Yes ☐ No

Has the employee been provided with a copy of this referral form?

☐ Yes ☐ No

If no, please explain:

4. REASON FOR REFERRAL

Please state clearly why occupational medical advice is being requested.

- ☐ Current sickness absence
- ☐ Recurrent or intermittent sickness absence
- ☐ Difficulty performing normal duties
- ☐ Fitness to return to work
- ☐ Fitness to remain at work
- ☐ Possible workplace accommodations
- ☐ Rehabilitation / phased return to work
- ☐ Health and safety concern
- ☐ Safety-critical duties
- ☐ Capability concerns
- ☐ Long-term prognosis / workforce planning
- ☐ Ill-health retirement consideration
- ☐ Other: _____

Please provide a concise factual summary of the reason for referral:

5. CURRENT WORK STATUS

- ☐ At work performing normal duties
- ☐ At work with temporary restrictions
- ☐ At work with modified duties
- ☐ On a phased return to work
- ☐ Absent from work
- ☐ Other: _____

If absent, date current absence commenced: _____

Current medical certification, if known: _____

Current restrictions or accommodations:

6. ATTENDANCE HISTORY

Please provide relevant sickness absence information, particularly any recurrent pattern or absence related to the current referral.

Absence during previous 12 months: _____

Absence during previous 24 months: _____

Relevant pattern or concern:

Please attach an absence record where relevant.

7. JOB DESCRIPTION AND ESSENTIAL DUTIES

Please describe what the employee actually does during a normal working day. A job title alone is insufficient.

Main duties:

Essential duties which the employee must be capable of performing:

8. JOB DEMANDS

Please identify the normal demands of the role.

Physical demands

- ☐ Prolonged sitting
- ☐ Prolonged standing
- ☐ Frequent walking
- ☐ Stairs
- ☐ Bending / kneeling / squatting
- ☐ Manual handling
- ☐ Lifting / carrying
- ☐ Repetitive movements
- ☐ Awkward postures
- ☐ Fine motor tasks
- ☐ Other: _____

Relevant details, including frequency, duration and weights where applicable:

Cognitive and psychological demands

- ☐ Sustained concentration
- ☐ Complex decision-making
- ☐ High workload
- ☐ Time pressure / deadlines
- ☐ Frequent interruptions
- ☐ Customer / patient contact
- ☐ Conflict management
- ☐ Emotionally demanding work
- ☐ Lone working
- ☐ Shift work / night work

☐ Other: _____

Relevant detail

Safety and environmental demands

- ☐ Driving
- ☐ Work at height
- ☐ Machinery
- ☐ Safety-critical work
- ☐ Responsibility for others
- ☐ Clinical / patient safety duties
- ☐ Biological exposure
- ☐ Chemical exposure
- ☐ Noise
- ☐ Heat / cold
- ☐ Required PPE

☐ Other: _____

Relevant hazards and controls identified in the Safety Statement or risk assessment:

9. FUNCTIONAL CONCERNS

Please describe any observed or reported difficulty relevant to the employee's ability to work.

- ☐ Physical capacity
- ☐ Endurance / stamina
- ☐ Ability to sustain a full working day or shift
- ☐ Consistency of performance
- ☐ Reliability of attendance
- ☐ Concentration
- ☐ Memory
- ☐ Decision-making
- ☐ Communication
- ☐ Mobility
- ☐ Manual handling
- ☐ Driving
- ☐ Safety-critical duties
- ☐ Other: _____

Please provide factual examples where available

10. WORKPLACE MEASURES ALREADY CONSIDERED OR TRIED

- ☐ Reduced hours
- ☐ Phased return to work
- ☐ Modified duties
- ☐ Temporary restrictions
- ☐ Altered working pattern
- ☐ Remote / hybrid working
- ☐ Ergonomic assessment
- ☐ Equipment modification
- ☐ Redeployment considered
- ☐ Formal risk assessment
- ☐ No measures considered to date

Details and outcome:

11. SCOPE FOR TEMPORARY MODIFICATION OF DUTIES

Can the employee's duties or working arrangements be temporarily modified?

- ☐ Yes ☐ No ☐ Uncertain

If yes, please describe what may reasonably be available:

12. SPECIFIC QUESTIONS FOR THE OCCUPATIONAL PHYSICIAN

Please tick the questions on which advice is required.

- ☐ Is the employee medically fit to perform their substantive role?
- ☐ Is the employee fit to return to work?
- ☐ If not currently fit, is a likely timescale for return identifiable?
- ☐ Are temporary restrictions required?
- ☐ Would a phased return to work be appropriate?
- ☐ Are workplace accommodations medically indicated?
- ☐ Is the employee capable of performing the essential duties of the role?
- ☐ Does the employee have sufficient **Capacity, Endurance, Consistency and Reliability (CECR)** to perform the role safely and sustainably?
- ☐ Is the employee's health likely to affect regular and reliable attendance?
- ☐ Is work likely to adversely affect the employee's health?
- ☐ Are there relevant safety implications for the employee or others?
- ☐ Is the condition likely to be short-term, prolonged or permanent?
- ☐ Is further occupational medical review recommended?
- ☐ Other specific questions:

1.

2.

3.

13. DOCUMENTS PROVIDED WITH REFERRAL

- ☐ Job description
- ☐ Absence record
- ☐ Relevant risk assessment
- ☐ Safety Statement information
- ☐ Previous Occupational Health report
- ☐ Relevant correspondence
- ☐ Other: _____

14. REFERRER DECLARATION

I confirm that, to the best of my knowledge, the information provided in this referral is accurate and relevant to the purpose of the occupational medical assessment.

Name: _____

Position: _____

Signature: _____

Date: _____

CONFIDENTIALITY AND CONSENT

The employee should ordinarily be informed of the reason for referral and provided with a copy of the referral information. Medical information should not be included unless it is necessary, relevant and proportionate.

The employee's consent to the occupational medical consultation and to the preparation and release of an occupational medical report will be addressed separately as part of the occupational medical assessment process.

The Occupational Physician will normally report on functional capacity, fitness for work, restrictions, accommodations, prognosis and occupational implications. Confidential clinical information will not ordinarily be disclosed to the employer without the employee's consent