GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Management request for an Occupational Health Opinion

Section A	**Employee Personal Details**
Title Mr ☐ Mrs ☐ Dr ☐ Ms ☐ Miss ☐ Other	Sex: Male: ☐ Female: ☐ Indeterminate/intersex/unspecified: ☐
Surname:	First name:
Previous names (if applicable):	Date of birth:
Home address:	
Post code:	Email:
Mobile telephone:	Home telephone:
Name of GP:	GP telephone:
Address of GP:	

Section B	**Job Details**
Job Title:	
Ward/department:	Division:
Site:	Work telephone:
Date of commencement in post:	

Section C	**Requesting Manager Details**
Name:	Job Title:
Ward/department:	Site:
Address:	
Telephone:	Email:

Section D	**Job Demands** (tick as appropriate)

Physical demands of job:

- ☐ Office based
- ☐ Regular lifting duties
- ☐ Standing for long periods of time
- ☐ Walking long distances
- ☐ Computer work
- ☐ Driving
- ☐ Fork lift truck driver
- ☐ Regular shift work
- ☐ Regular night work
- ☐ Control and restraint issues
- ☐ Emotionally demanding

Work environment:

- ☐ Contact with bodily fluids
- ☐ Contact with biological hazards
- ☐ Contact with chemicals
- ☐ Food handler
- ☐ Exposure to dust or fumes
- ☐ Exposure to noise
- ☐ Working at heights/confined spaces
- ☐ Use of vibrating tools
- ☐ Exposure to verbal/physical aggression
- ☐ Protective clothing required (please specify)
- ☐ Extreme temperatures

Please provide details of any specific workplace issues relating to identified areas above

Section E	**Reason for Referral**
Currently in work	☐ Yes ☐ No
Reason for referral:	☐ Long term absence - Date absence commenced: ____/____/____ - Date current fit note up until: ____/____/____ - Reason for absence stated on most recent fit note: ____ ☐ Short term frequent absence ☐ Health condition affecting work fitness ☐ Other (please state) ____
Please provide further details:	
If the reason relates to a musculoskeletal condition please also complete **section F** to give more detail	
If the reason relates to a mental ill health condition please also complete **section G** to give more detail	
Sickness Absence Record (please attach relevant details for the past 12 months including reasons for absence, length of absence, time absence began:	
Details of any perceived obstacles **that manager is aware of that could interfere with returning to work:**	
Job specification (please attach a copy of the job description)	

Alterations/adaptations/reasonable adjustments that <u>have already been made</u> to assist the employee (please tick)

☐ Reduced hours ☐ Redeployment ☐ Redefined duties

☐ Use of special equipment ☐ Phased return

☐ Other: _____

To aid an early return to work, if relevant, please state what modified duties you or your member of staff think could be carried out:

Section F To be completed if referring for a musculoskeletal condition

Main issue/s:		
Date of onset of symptoms:		
Previous physiotherapy treatment for this condition?	Yes ☐	No ☐
Successful outcome of treatment?	Yes ☐	No ☐
Significant reduction in activities of daily living?	Yes ☐	No ☐
Sleep disturbance due to this condition?	Yes ☐	No ☐
Has a referral been made to another clinic/consultant for this condition? If yes please give details below.	Yes ☐	No ☐

Additional information:

Section G To be completed if referring for an emotional wellbeing or mental health condition		
Main issue/s including date of onset of symptoms:		
Formal diagnoses e.g. clinical depression, anxiety disorders such as PTSD, obsessive compulsive disorder. If yes please state:	Yes ☐	No ☐
Current symptoms e.g. Low mood	Yes ☐	No ☐
Poor motivation	Yes ☐	No ☐
Anger	Yes ☐	No ☐
Worry	Yes ☐	No ☐
Agitation	Yes ☐	No ☐
Feeling chronically stressed	Yes ☐	No ☐
Fatigued	Yes ☐	No ☐
Other please state:		
The following are based on the Health & Safety Executive's stress management standards and relate to workplace factors which if not proactively managed can impact on staff wellbeing.	**Contributing to illness and/or absence**	
Demands including issues like workload, work patterns and the work environment	Yes ☐	No ☐
Control i.e**.** how much say they have in the way they do their work	Yes ☐	No ☐
Support which includes resources provided by the organisation, line management and colleagues	Yes ☐	No ☐
Relationships which includes conflict and unacceptable behaviour	Yes ☐	No ☐
Role e.g. whether they understand their role within the organisation, whether they have conflicting roles	Yes ☐	No ☐
Change i.e**.** how workplace changes, large or small, are managed and communicated.	Yes ☐	No ☐
If you answered yes to any of the 6 areas identified above please give details of what has **already been put into place** to support the member of staff:		

Section H	**Advice Required** *(please tick)*
☐	Is the person fit to return to normal unrestricted duties of work?
☐	Is the person fit to return to modified duties of work?
☐	If modifications are required are they temporary or permanent? Please state time scale if temporary.
☐	Does the person need to be relocated to a different post? If yes, are there any specific recommendations about this?
☐	If none of these – is early retirement on grounds of ill health appropriate?
☐	Is the condition likely to be covered by the Equality Act 2010?
☐	Other advice required (please specify):

Section I Confirmation that the member of staff understands reason for referral.

This section must be signed by the employee and only in EXCEPTIONAL circumstances will a referral form be accepted unsigned. Failure to sign this section may result in the referral form being returned and any appointment or assessment delayed.

I consent to being assessed in the Occupational Health Department and I have read and had the reason for this explained to me. I understand that any medical details discussed will remain confidential, and that my manager will only be informed of facts that relate to my employment and ability to work. I also understand that following the appointment Occupational Health will request my consent to send a report to my manager with a copy to my GP. The proposed contents of the report will be discussed with me in advance and I will be provided with a copy of the report for my own information as a matter of good practice. Should it be necessary for the Occupational Health Department to obtain a medical report from my GP or specialist I understand that this will only be done with my written permission.

If you are in doubt about why you are being asked to attend you should discuss this further with your manager before signing below.

Signed: …… Date: ____/____/____
Member of staff

Signed: …… Date: ____/____/____
Referring Manager

Further guidance is available from Occupational Health on telephone numbers:

St Woolos 01633 238349 Nevill Hall 01873 732849 Ysbyty Ystrad Fawr 01443 802442

Occupational Health Use Only:

Appointment with: ☐ Consultant _____

☐ Doctor _____

☐ Senior OH Nurse advisor _____

☐ OH Nurse advisor _____

Method: ☐ Telephone ☐ Face to face appointment

Appointment duration: ☐ 30 min ☐ 40 min ☐ 60min

Priority: ☐ Urgent ☐ Routine

Additional information:_____

_____

Action determined by: Name _____Signature_____