**Please complete all boxes**

**\*\*\*\*THIS FORM MUST BE SIGNED BY THE EMPLOYEE\*\*\*\***

**EMPLOYER TO COMPLETE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Employer Company Name: |  | | | |
|  |  |  |  |  |
| Employer  Contact Name: |  | | | |
|  |  |  |  |  |
| Employee First Name: |  |  | Employee Surname: |  |
|  |  |  |  |  |
| Employee home address inc postcode | Address: | | | |
|  | Postcode: | | | |
|  |  | | | |
| Employee  Date of Birth: |  | Employee Contact Phone Number: | |  |
|  |  | | | |
|  |  |  |  |  |
| Employee  Email address: |  | | | |
|  |  |  |  |  |

**please tick service(s) required**

|  |  |
| --- | --- |
|  |  |
| 1. Clinical Support Service (nurse support calls) |  |
| 1. Occupational Health Assessment |  |
| 1. Private Counselling / CBT therapy |  |
| 1. Functional Capacity Evaluation |  |

**EMPLOYEE TO COMPLETE**

**Guidance for employees referred to the Absence Management service**

WTW provides services to support employees who are (or likely to become) absent from work due to a medical condition. The services are:

1. **Clinical Support** from aRegistered Nurse or Physiotherapist to provide medical advice and help you access treatments you may need to improve your health.

2. **Occupational Health Assessment -** assessments which aims to understand the nature of your medical condition and how this may affect you in your job.

3. **Private Counselling / CBT therapy –** consent is required to source a suitable therapist or counsellor for private therapy sessions. This can be funded by your Organisation or private medical insurance scheme.

4. **Functional Capacity Evaluation –** indepth assessment to understand your capacity to undertake your job role.

Your employer has referred you to one or all of these services. You need to give separate explicit informed consent to use these services, because they all will deal with different aspects of your medical condition. You will also need to give consent so that the service can request medical notes from your general practitioner or other specialist, if required.

* Referred to the Clinical Support Service – complete sections A, D & E
* Referred for an OH Assessment or Functional Capacity Evaluation (FCE) – complete sections B, C, D & E
* Referred to both – complete sections A, B, C, D & E
* Referred for counselling/therapy – complete sections C, D and E
* Don’t forget to sign section E with a wet signature

**Consent Section**

**A YES or NO must be placed in each box**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Section A Yes or No**   |  |  |  | | --- | --- | --- | | I consent that a registered general nurse from the Clinical Support Service may contact me |  |  | |  |  |  | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section B Yes or No**   |  |  |  |  | | --- | --- | --- | --- | | I consent to undergo an Occupational Health Assessment / FCE. The purpose of the assessment has been explained to me by my Manager/HR Department | |  |  | |  | |  |  | | **I wish to see a copy of the occupational health report:** | |  | **Tick one option** | | at the **same time** as my employer | |  |  | | **before** it is sent to my employer | |  |  | | Following your assessment, a report will be sent to your Manager and/or HR Department with your agreement and the contents of the report will be discussed with you at the end of the consultation. You may choose to review the report before it is sent to your employer. Having been given access to the report, it cannot be sent without your consent. Before giving your consent, you have the right to ask your OH clinician to amend or delete any part of the report, which you consider inaccurate. If the Clinician declines, you may require the inclusion of an addendum statement of your views at the end of the report. You also have the right to withdraw your consent to provide the OH report to your employer at any time during the process.  **We will email a copy of the OH report to you.**  Please provide us with a preferred email address. The report will be sent to your employer 3 working days later, if you have requested to see the report first. | | | | | **Employee’s preferred email address:** |  | | | |  |  | | | |
| **Section C**   |  |  |  |  | | --- | --- | --- | --- | | To enable our Occupational Health Team to formulate appropriate advice, we may need to contact your General Practitioner/Family Doctor and/or Specialist to obtain medical information. This is covered by the legislation in the **Access to Medical Reports Act 1988** – please read your rights under this Act summarised below. We will only contact your treating doctor/s if it is necessary and with your written consent.  If you agree to us contacting your doctor please **complete your doctor’s details:** | | | | | Doctor’s name: |  |  | | |  |  |  | | | Doctor’s practice and address: |  |  | | |  |  | | | | Hospital specialist’s name: |  |  | | |  |  |  | | | Hospital name and address: |  |  | | |  | **Yes or No** | | | | **I wish to see/receive** a copy of the General Practitioner and/or Specialist’s report **prior** to the release to Occupational Health | | |  | |  | | |  | | **I wish to see/ receive** a copy of the General Practitioner and/or Specialist’s report **at the same** time as the release to Occupational Health. | | |  | |  | | |  | | **I do not wish** **to see/receive** a copy of the General Practitioner/and or Specialist’s report provided to Occupational Health. | | |  | | **Notes on Access to Medical Reports Act 1988**  This Act gives you the right to have access to any report about you which is written for employment or insurance purposes by a registered medical practitioner (doctor) involved in your clinical care. (Please note that the Act does not apply to the occupational health report as the physician is not involved in your clinical care).   * You may withhold your consent to a medical report being supplied. * You have the right to inspect or be supplied with a copy of the Doctor’s report before it is sent to the person requesting the report. * When you have indicated your wish to see the report, you must make arrangements with the Doctor within 21 days of the date on the consent form. If you do not do so, the Doctor may send the report without you seeing it. * Having been given access to the report, it cannot be sent without your consent. Before giving your consent, you have a right to ask your Doctor to amend or delete any part of the report, which you consider inaccurate or misleading. If the Doctor declines, you may require the inclusion of a statement of your views within the report. * The Doctor has the right to deny access to the report or a part of it if, in the opinion of the Doctor, it may cause you serious physical and/or mental harm or would cause problems for a third person who has not consented. If the Doctor believes you should not have access to the report, you will be notified. The report cannot be forwarded to the person requesting it without your consent. * You will continue to have the right to apply for access to the report for 6 months after it has been prepared. | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| **Section D Yes or No**   |  |  |  | | --- | --- | --- | | I consent to my personal and medical information being shared between the clinical support service, the occupational health service and relevant Insurers. Please note, this will enable all WTW services to work together to help you return to work. |  |  | |  |  |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Section E**  **I have added Yes and No to the relevant areas in this document to indicate my consent.**     |  |  | | --- | --- | | **Signed:** |  | | **Date:** |  | |

|  |
| --- |
| **Notes – any further information you think may be relevant:** |