**Please complete all sections – failure to do so may result in processing delays**

**EMPLOYER TO COMPLETE:**

**This form should be forwarded along with a completed Consent Form to:** **hbgb.oh@wtwco.com**

**Employer Details**

|  |  |
| --- | --- |
| Name of Referring Manager /HR: |  |
|  |  |
| Tel: |  |
|  |  |
| Email: |  |
|  |  |
| Billing Company: |  |
|  |  |
| Billing Department: |  |
|  |  |
| Billing Address & postcode: |  |
|  |  |
| Purchase Order number (if applicable): |  |
|  |  |
| Anonymity Code (if applicable): |  |

**Service Required**

**Choose option 1 or 2 and tick type of service required:**

1. **Ad Hoc Referrals:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| OH Appointment with OH Physician: | Face to face |  | Telephone |  | Video /Teams |  |
|  |  |  |  |  |  |  |
| OH Appointment with OH Advisor: |  |  | Telephone |  | Video /Teams |  |
|  |  |  |  |  |  |  |
| Ad hoc Absence Case Management: | Telephone | | |  |  | |
| (nurse led clinical support calls): | | | | | | |

1. **Absence Concierge Package (prepaid):**

|  |  |  |  |
| --- | --- | --- | --- |
| OH Appointment with OH Clinician: |  |  |  |
|  |  | | |
| Clinical support calls with a nurse: |  |  |  |
|  |  |  |  |

**Please complete all sections in full**

**Reason for Referral**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medical Condition/s: | |  | | | |
|  | |  | | | |
| Is the employee currently off sick? (please circle) | Yes/ No | | Date of first absence: |  | |
|  | | | | |  |
| **\*I can confirm the information provided on this referral form has been shared with the employee being referred into our services (please circle)** | | | | | Yes/ No |

# **Employee Details**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First Name: |  | | | | Surname: | | | |  | | | | | |
|  |  | | | |  | | | | |  | | | | |
| Home address: |  | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | |
| Postcode: |  | | | | | | | | | | | | | |
|  |  | | | |  |  | | | | | | | | |
| Date of birth: |  | | | | Contact Number: | | | | | |  | | | |
|  |  | | | |  | |  | | | | | | | |
| Preferred Email: |  | | | | Office based: | | | | |  | | | Hybrid: |  |
|  |  |  |  |  | | | |  | | | |
| Job Title: |  | | | | Gender: | | | | | M/F/NB | | |

**Please state below any dates the employee is not available:**

(including shift patterns, GP & hospital appointments and childcare issues etc):

|  |
| --- |
|  |

**Please note, we will assume that any appointment time is suitable if left uncompleted - charges may apply for the necessary reschedule of appointments**

**HR to enclose:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| A copy of the most recent medical certificate | Yes |  | No |  |
|  |  |  |  |  |
| The completed Consent Form – the referral cannot be progressed without this | Yes |  | No |  |
|  |  |  |  |  |
| Employee’s availability completed (Mandatory) | Yes |  |  |  |
|  |  |  |  |  |

**Please complete all sections in full**

**Background: Reason for Absence/Referral**

Please answer each of the following questions:

1. Details of absences - brief summary of relevant and current information including dates and reasons for absence.

|  |
| --- |
|  |

1. Is the employee entitled to company sick pay? If so, when will company sick pay run out i.e. please give a specific date?

|  |
| --- |
|  |

1. Any capability, disciplinary, performance issues/work related issues or outstanding grievances?

|  |
| --- |
|  |

1. Any company health benefits available to this employee e.g. EAP, private medical insurance, IP etc?

|  |
| --- |
|  |

1. Has your employee self-funded any treatment of their own? If not, is the company willing to assist with private funding e.g. counselling?

|  |
| --- |
|  |

1. Has the employee given you any indication of when they may be fit to return to work i.e. an estimated date?

|  |
| --- |
|  |

1. Are there any options of alternative duties/roles available on a temporary basis for this employee?

|  |
| --- |
|  |

1. Please provide details of any adjustments already considered/implemented and advise of any restrictions that the clinician needs to be aware when make further recommendations.

|  |
| --- |
|  |
|  |

**The medical report will cover the following points unless otherwise specified:**

* **Medical issues and background, in general terms**
* **Current and planned treatment (with an idea of timescales if appropriate)**
* **Nature of current functional incapacity**
* **Current and likely future fitness for work, with timescales if appropriate**
* **Adjustments/restrictions required (temporary or permanent), including if appropriate obstacles to return to work**
* **Guidance as to whether the individual is likely to be considered disabled as defined by the Equality Act 2010 (UK)/Irish Human Rights and Equality Commision Act 2014.**

**Any other specific questions to be reviewed during the OH assessment & details of any - Maximum of 10 questions. Please note, significant additional questions may incur an extended consultation fee.**

|  |  |
| --- | --- |
|  |  |
|  |  |

**Job Details**

**Please attach a copy of the Job Description.**

**Please complete this section describing the employee’s current job inserting X where appropriate:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Duties** | **Yes** | **No** |  | **Comments** |
|  |  |  |  |  |
| Work full-time/part time: (how many hours?) |  |  |  |  |
|  |  |  |  |  |
| Driving: Group 1 (ordinary driving licence) |  |  |  |  |
| Group 2 (LGV/PSV)/Lift Trucks/Other |  |  |  |  |
| Please specify weight of vehicle, traffic conditions, duration and frequency | | |  |  |
| Lifting requirements: |  |  |  |  |
|  |  |  |  |  |
| Bending/kneeling/crouching/squatting: |  |  |  |  |
|  |  |  |  |  |
| Climbing requirements/working at heights |  |  |  |  |
|  |  |  |  |  |
| Confined space work: |  |  |  |  |
|  |  |  |  |  |
| Work in wet/hot/cold environments: |  |  |  |  |
|  |  |  |  |  |
| Shift work including nights: |  |  |  |  |
|  |  |  |  |  |
| Working alone / Home working: |  |  |  |  |
|  |  |  |  |  |
| Close vision work: |  |  |  |  |
|  |  |  |  |  |
| Work requiring precise hand/eye co-ordination: |  |  |  |  |
|  |  |  |  |  |
| DSE (VDU) work: |  |  |  |  |
|  |  |  |  |  |
| Public contact: |  |  |  |  |
|  |  |  |  |  |
| Work involving call handling: |  |  |  |  |
|  |  |  |  |  |
| Work in dust/fumes/gases/vapours: |  |  |  |  |
|  |  |  |  |  |
| Work with vibrating tools: |  |  |  |  |
|  |  |  |  |  |
| Work with skin irritants: |  |  |  |  |
|  |  |  |  |  |
| Work requiring Personal Protective Equipment: |  |  |  |  |

**Does the employee need assistance with any of the following during the appointment:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Requirement** | **Yes** | **No** |  | **Comments** |
|  |  |  |  |  |
| Wheelchair access required? |  |  |  |  |
|  |  |  |  |  |
| Mobility issues? |  |  |  |  |
|  |  |  |  |  |
| Hearing Impairement? |  |  |  |  |
|  |  |  |  |  |
| Vision Impairment? |  |  |  |  |
|  |  |  |  |  |
| Speech Impediment? |  |  |  |  |
|  |  |  |  |  |
| Language barrier (translator required)? |  |  |  |  |
|  |  |  |  |  |
| Other (please detail in comments) |  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Terms and Conditions of service**

* \*Ensure your employee has understood the purpose of, and consented to, the consultation prior to the referral to WTW.
* Please note, unless management referral forms and consent forms are completed in full, WTW may be unable to process appointments.
* Dependant on complexity of the case, as extended consultation charge may be applied on a pro-rata basis.
* Please note, it is your responsibility to confirm all appointments regarding sickness absence/management referrals to your company employees and to confirm their attendance.
* For cases where additional medical information is sought, a fee for the GP/Specialist report will be chargeable.
* Please note that cancellations or alterations to appointments with less than 5 working days’ notice will be subject to the full fee.

**This form should be forwarded along with a completed Consent Form to:**  [hbgb.oh@wtwco.com](mailto:HBGB.OH@willistowerswatson.com)