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

**Please can you complete the following form with details of the individual making the referral. Please also include details of the individual being referred for a Functional Capacity Evaluation (FCE) and any work-related information, e.g., job description, any up-to-date GP, Specialist or OH reports relevant to this case.**

**Employer Details**

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

|  |  |
| --- | --- |
|  |  |
| Who is the report to be sent to? |  |
|  | |

# Employee Details

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

**Referral Details**

|  |  |
| --- | --- |
| Reason for Referral: |  |
|  |  |
| Current duties: Please give details of tasks that are being completed in full |  |
|  |  |
| Contracted Working hours per day / week: |  |
|  |  |
|  |  |
| Restricted, modified or avoided tasks |  |
|  |  |
| Current Working Hours/Patterns (if reduced) |  |

|  |  |
| --- | --- |
| How long have the restricted duties been in place |  |
|  |  |
| Number of days absent from work in last 12 months: |  |
|  |  |
| Length of time in current role: |  |

**Please complete the table below with the tasks that are relevant to the individual’s full role and any associated loads handled.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Task / frequency** | **Never** | **Occasionally (0-33%)** | **Frequently (34%-66%)** | **Constantly (67%-100%)** | **Weight (kg)** |
| Lifting floor to waist height |  |  |  |  |  |
| Lifting waist height to head height |  |  |  |  |  |
| Carrying |  |  |  |  |  |
| Pushing |  |  |  |  |  |
| Pulling |  |  |  |  |  |
| Overhead work standing (head height) |  |  |  |  |  |
| Forward bending work |  |  |  |  |  |
| Repetitive bending / reaching |  |  |  |  |  |
| Repetitive side reaching |  |  |  |  |  |
| Repetitive gripping |  |  |  |  |  |
| Kneeling / squatting |  |  |  |  |  |
| Walking |  |  |  |  |  |
| Steps / stairs |  |  |  |  |  |

**\*Please note, all details on this form will be shared with the employee during the assessment.**

**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.