Information & Criteria for Management Referrals/self referrals to Occupational Health Department

Dear managers/staff,

- The Occupational Health Department provides an independent, confidential advisory service to both the HSE as the employer and staff members on all matters relating to the effect of health on work and work on health.

- In relation to management referrals the line manager should discuss the referral with the staff member and ensure that the staff member is fully aware of the reasons for referral. The line manager should obtain written consent from the referred employee for the Occupational Health consultation. To ensure the best information is properly obtained it is essential that all relevant background information is provided.

- If further information is required from your GP or other health care professional at consultation the Occupational Health professional will discuss this with the employee and request their consent to seek a report.

- The Occupational Health Department will provide a report to the line manager and the employee will receive a copy of this report. The employee will be advised of the opinion given by the Occupational Health professional at the time of the appointment.

- If a referral is not correctly completed the manager/employee may be contacted to clarify details or the form may be returned. **Appointments will only be made on receipt of an adequately completed referral form**.

- Attached is the ***'Referral Form'*** which consists of **4 pages** and which should be **completed in full** and returned to the **Occupational Health Department, University College Hospital, Galway**.

Criteria for referral to Occupational Health Department

Referrals are recommended in the following circumstances:

- where there is altered work performance / safety concerns
- where work is affecting health i.e. work related injuries / illness
- where health maybe affecting work
- for assessment regarding rehabilitation / resettlement and redeployment
- for assessment for ill health retirement

Occupational Health Department HSE West Contact Details:

UCHG: 091 542910 **Mayo**: 094 9042018 / 9042005 **Roscommon**: 090 6632282

Email: occupational.healthuhg@hse.ie

Occupational Health Department,

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

H.S.E. West,
University Hospital,
Galway.
(091) 542910.
Fax: 091 542428.
E-mail: Occupational.HealthUHG@hse.ie

1.1 PERSONAL DETAILS

Full Name:_____Title: Mr. ☐ Mrs. ☐ Ms. ☐ Prof ☐

Staff Number: _____D.O.B. _____ Age: _____

Home address: _____

_____

Home Phone Number: _____ Mobile Number: _____

Are there any particular requirements in relation to access, mobility or communication Yes ☐ No ☐

If yes, give details_____

Job Title:_____Department_____Hospital/Service_____

Work Pattern: Full-time ☐ Part-time ☐ Job share ☐ Shift-work: Yes ☐ No ☐

1.2 JOB DEMANDS: Please tick all relevant boxes √

Physical Demands		Environmental Demands i.e. regular / frequent exposure to		Work Location		Other Demands	
Deskwork		Noise		Office		Teaching	
Standing		Dust or fumes		Laboratory		Demonstrating	
Lifting or carrying		Chemicals		Lecture Theatre		Clinical Work	
Computer Work		Biological hazards		Workshop		Management of Staff	
Operating machinery		Work at heights		Outdoors		Research	
Driving		Work in confined spaces		Mobile around site			
Bending/stooping		Fieldwork		Offsite			
Twisting upper body		Travel abroad		Other			
Arms above shoulder height		Use of vibrating tools					
		Lone working					

1.3 CURRENT WORK STATUS

Is the member of staff currently on sick leave? Yes ☐ No ☐
If yes, how long has the staff member been on sick leave? _____

_____

When does the current medical certificate run to? _____

What is the reason given for this absence? _____

Sickness Absence Record (last 24 months)

Date from	**Date to**	**Number of work days lost**	**Reasons given for absence on certificate**

1.4 REASON FOR REFERRAL

Tick all appropriate boxes then give details.

Long term absence greater than 4 weeks/return to work assessment following long term sickness absence ☐

Concern over performance ☐ Concern over attendance ☐

Long term absence ☐ Return to work following accident at work ☐

Assessment after accident at work ☐ Safety Issue ☐

Possible work related health problem ☐ Disability Assessment ☐

Fitness for re-deployment ☐ Consideration for Medical Retirement ☐

Other *(please specify)* ☐ _____

Please provide full details in relation to this referral:

_____
_____
_____
_____
_____
_____
_____

1.5 PLEASE TICK THE QUESTIONS THAT YOU WOULD LIKE OCCUPATIONAL HEALTH TO ADDRESS

☐ Is there any underlying health problem that may affect attendance or performance?

☐ If so what is the likely time scale for recovery and/or when do you anticipate a return to work?

☐ Are there any short-term restrictions to the work tasks or environment that would help facilitate rehabilitation or an early return to work?

☐ How long would you expect these restrictions to apply?

☐ Are there any permanent adjustments to the work tasks or environment recommended?

☐ If and when the person returns to work, will they be able to carry out the duties outlined on this form and their job description?

☐ Is the person permanently unfit and will they meet criteria for medical retirement?

☐ Consideration for Injury grant and Percentage Impairment as per article 49 and or 109

Details:

_____

_____

_____

_____

_____

_____

1.6 MANAGER'S CHECKLIST

I have explained to the staff member the reason for this referral Yes ☐ No ☐

If yes when and how_____

Has this person been referred for assessment before? Yes ☐ No ☐ If yes when_____

Employee's written consent obtained Yes ☐ No ☐

I enclose: The person's job description ☐ any other relevant documents ☐

Name of person making referral (Block Capitals) _____

Position: _____Department_____Hospital/Service_____

Contact Telephone Number: _____

Address:_____

Signature: _____Date: _____

PLEASE NOTE THAT ANY INFORMATION INCLUDED ON THIS REFERRAL WILL BE DISCUSSED WITH THE INDIVIDUAL BY THE OCCUPATIONAL HEALTH DEPARTMENT.

PLEASE SEND THE COMPLETED FORM IN A SEALED ENVELOPE MARKED CONFIDENTIAL DIRECTLY TO OCCUPATIONAL HEALTH DEPARTMENT, UNIVERSITY COLLEGE HOSPITAL, GALWAY.

Use Only by OHD

Client Name:

Date received in Occupational Health (stamp in the box please)

To be completed by Occupational Physician of Occ. H. N in absence of Occ. Physician.

Referral reviewed by _____ on _____

Other information required? Yes ☐ No ☐

From whom? ☐ Line manager ☐ employee ☐ medical advisor ☐ other

Details? _____

_____

_____

Appointment should be offered in: ☐ 1-2 week's ☐ 2-4 weeks ☐ 4-6 weeks ☐ 6-8 week's ☐ Other

Appointment should be with O.P. ☐ OHN ☐

To Be completed by Administrator

Appointment given on _____

To be seen by _____

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Occupational Health Department,
H.S.E. West,
University Hospital,
Galway.
☎ 091 542910
Fax (091) 542428.
Email: Occupational.healthUHG@hse.ie

To be completed by the employee referred to the Occupational Health Department

I have been advised by my manager of the reasons for my referral to the Occupational Health Department and give my consent to a consultation/assessment/examination.

I understand that the Occupational Health Department will provide a report regarding my fitness to work to my employers and that I will receive a copy of this report.

Employee's Name in Block Capitals _____

Date of Birth _____

Employee's Signature _____

Date _____