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
### 1.1 PERSONAL DETAILS

<table>
<thead>
<tr>
<th>Full Name: ________________________________________________</th>
<th>Title: Mr. □ Mrs. □ Ms. □ Prof □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Number: _____________________________________________</td>
<td>D.O.B. ___________________ Age:</td>
</tr>
<tr>
<td>Home address: ______________________________________________</td>
<td>________________________________</td>
</tr>
<tr>
<td>Home Phone Number: ___________________________ Mobile Number: _____________________</td>
<td></td>
</tr>
</tbody>
</table>

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 √

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

<table>
<thead>
<tr>
<th>Date from</th>
<th>Date to</th>
<th>Number of work days lost</th>
<th>Reasons given for absence on certificate</th>
</tr>
</thead>
</table>

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.
Client Name:

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

To be completed by Occupational Physician of Oce. 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 ______________________________
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 ________________________________