**On-Offer Referral Form**

**Referral for Occupational Health advice following an offer of employment** - to be completed in consultation with your HR Schools team.

**Data Protection information**

The information supplied on this questionnaire will be held in confidence by the University Occupational Health Service as part of the individual’s occupational health record.  For full details of how an individual’s personal information is used by the Occupational Health Service, please see <http://www.oh.admin.cam.ac.uk/general-information/confidentiality-statement>

Once completed please send the form to Occupational Health, 16 Mill Lane, Cambridge CB2 1SB or as an attachment to an email at [occhealth@admin.cam.ac.uk](mailto:occhealth@admin.cam.ac.uk) on the understanding that the following guidance is followed:

1. The email subject line must not contain any confidential information about the employee. Please state **Occupational Health referral** in the email subject box.
2. The confidential email must only be shared with the employee and named departmental / HR professional; **not forwarded on to any other person** without the consent of the employee**.**
3. A copy of the form must filed in the employee’s personal file.
4. **Applicants details**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Surname: |  | | Mr / Mrs / Miss / Ms / Dr / Prof / Other | | | | |
| First names: |  | | Date of birth | |  | | |
| Position type: Academic / Academic related / Assistant / Student (if applicable) | | | | | | Grade: |  |
| Post title: |  | | Department | |  | | |
| Proposed start date: | |  |  | | | | |
| Department address: | |  | | | | | |
|  | |  | | | | | |
| Place of work, if different from department address: | |  | | | | | |
|  | | | | | |
| Home address: | |  | | | | | |
|  | |  | | | | | |
| Mobile: | |  | Email: |  | | | |

|  |  |
| --- | --- |
| Are there any particular requirements in relation to access, mobility or communication? If yes please give details: | |
|  | |
|  | |
| Please provide a brief overview of the job description of the employee including tasks, hours, overtime and | |
| location: |  |
|  | |
|  | |

1. **Details of manager requesting assessment**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: |  | | Job title: |  | | |
| Department: |  | | | | | |
| Contact telephone number: | |  | Email address: | |  | |
| HR adviser’s name: | |  | Copy of report required: | | | Yes  No |

1. **Reason for referral**

|  |
| --- |
| *Please outline the main reason for initiating this request, including, if relevant, the effects of the health problem on work performance and attendance as stated by the applicant.* |
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**4. Referral questions** – *please indicate which questions you seek guidance on from Occupational Health*

4.1  Is there an underlying health condition that may impact on the individual’s work performance / health / attendance?

4.2  Are any adjustments to the work tasks, environment or working time recommended?

4.3  Is there any additional help or treatment you could recommend?

4.4  In your opinion should the employee/student be able to provide reliable and consistent future attendance?

4.5  In your opinion does the health condition meet the disability provisions of the Equality Act 2010?

4.6  Other - if any additional questions or specific advice is required please state this below:

|  |
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**5. Referral authorisation** *the referring manager named above should complete this section*

Please complete the following by ticking the boxes below:

I confirm that I have discussed the reasons for this referral with the applicant and departmental HR adviser.

I am aware that the applicant will receive a copy of the resulting report.

If completing electronically please type your name below. This indicates your agreement to the above statements (section 5) and must be emailed from your named Cambridge email account. Alternatively, print the form, sign and scan as a PDF file.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | Date: |  |

**Office use only:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| OHP appointment | |  | SOHA appointment |  | OHA appointment | |  |  |
| Telephone consultation | |  | OHP |  | OHA | |  |  |
| SOHA signature: |  | | | | | | | |
| Print name: |  | | | | | Date: |  | |