INDEPENDENT MEDICAL ASSESSMENT – REQUEST FORM

This request form should also include a summary of the relevant background information, the reasons for referral and the relevant questions to which an answer is required.

Please complete all sections of the form and return to:

Occupational Health South West Ltd
Applewood, Quarry Road
Bolingey
Perranporth
Cornwall TR6 0AS

helentellam@ohsw.co.uk
www.ohsw.co.uk

01872 572 553

TO BE COMPLETED BY REFERER

SECTION A – Your Company Details	
Company Name:	
Name of HR or Referrer:	
Email Address:	
Telephone No:	
Full Address of Company:	

SECTION B – Personal Details for Person Being Referred			
First Name		**Surname:**	
Title (Mr/Ms/Miss etc.):		**Date of Birth:**	
Work Telephone:		**Department:**	
Home Address:			
Home Telephone:		**Mobile Telephone:**	
Employee's Job Title (If Possible attach job description):			

SECTION C – Type of Assessment Required	
Independent Medical Assessment Appointment by an OH Physician:	YES / NO
Desktop OH Physician File Review Only:	YES / NO

SECTION D – Reasons for Referral	
Sickness absence (employee not at work at present):	YES / NO
Poor attendance (employee at work – frequent short term absence):	YES / NO
Health Concern affecting work performance – if so, elaborate below:	YES / NO
Provide any issues of concern:	

SECTION E – Sickness Absence History (enter details for the last three years)			
Date:		**Days' absence:**	
Details of Illness:			
Date:		**Days' absence:**	
Details of Illness:			
Date:		**Days' absence:**	
Details of Illness:			
Date:		**Days' absence:**	
Details of Illness:			
Date:		**Days' absence:**	
Details of Illness:			

SECTION F – Sample Questions Please indicate which of these specific questions you may wish the OH Physician / Advisor to address in this report. Please elaborate in Section G.	
Is there an underlying medical reason for the attendance record?	YES / NO
Is there an underlying medial reason for the performance record, as described below?	YES / NO
What are the timescales for recovery and resumption to work?	YES / NO
Is there a probability of any residual impairment on resuming work?	YES / NO
What is the likelihood of being able to give regular and effective performance in the future?	YES / NO

Please advise on any work restrictions, readjustments or redeployment.	YES / NO
Would disability legislation apply and is there any advice you would give to comply?	YES / NO
Is the employee permanently unfit?	YES / NO

SECTION G – Specific Referral Questions
Please outline below any specific questions to be addressed by the OH Physician or Nurse Advisor including any relevant background information such as recent job changes, work place issues, performance concerns etc.

Checklist: Have you included the following where relevant:

- *Sickness absence record*
- *Job Description*
- *Any relevant correspondence/medical papers*

SECTION H – Confirmation and Signature **I confirm that the employee has been notified of this referral:**			
Name of referrer:		**Position of referrer:**	
Signature:		**Date:**	

SECTION I – Invoicing
Please outline any details for the invoice. i.e. whether a PO number will be required. Please include a contact name and email address for your accounts department where applicable.