**Occupational Health Referral – Part A**

To be completed by the Line Manager (or Delegate)

The following employee ……………….................................… employed as a(n) ………………………………………. has been referred to you for an occupational assessment.

Mr. /Ms. ……………………………..…. has been unable to attend work since ……………………….. (Date) due to the following conditions:

…………………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………

With reference to the above condition, please complete the attached form to be returned to a National

Ambulance Clinical Operations Manager.

**The NA Medical Director/delegate and Human Resources Department are to be advised by e-mail of each case where an employee is absent for 7 days or more by the relevant line manager due to illness.**

Referred by: ................................................... Job Title: ………………………………………………...

Email address: ……………………………………………. Mobile number: ………………………………………

Date: ...............................................................

**Occupational Health Referral – Part B**

To be completed by the NA Employee

By signing above, the employee acknowledges that he/she will return the following documents to a Line Manager (or delegate)

Occupational Health Referral Form completed, signed and stamped by a licensed clinician (for pregnancy a licensed obstetrician)

Sick certificate (signed and stamped by the licensed attending clinician) and any other relevant medical documentation

Employee Signature: …………………………………………...

Date of Receipt: ………………………………………………….

**Occupational Health Referral – Part C**

To be completed by the attending clinician

Employee Name: ………………………………………………………………………...

1. Diagnosis: ………………………………………………………………………………………………………………

2. Is the employee able to continue his/her normal workplace duties? Yes □ No □

1. If no, how many days/weeks will the employee be off duty? ..........................................

b. If no, is the employee able to work light duties? Yes □ No □

c. If yes, how many days/weeks is the employee recommended for light duties? ....................

3. Is the condition of the employee chronic or likely to be chronic? Yes □ No □

4. If yes, is this a condition that is likely to cause the employee to have further periods of absence due to their condition? Yes □ No □

Details: ……………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………

5. Does the employee require any additional treatment/therapy/tests? Yes □ No □

6. If yes please explain and possible length of treatment required …………………………………………………….

.....................................................................................................................................................................

7. If the employee is pregnant please state expected date of delivery. …………………………………………………………………….

8. Is the employee fit to work long-term (as per contract)? Yes □ No □

9. Please complete and attach a DOH/DHA/MOH sick leave certificate and light duty notification certificate and other relevant documents and return to National Ambulance with the following information:

a. Sick leave start date

b. Last sick leave date. Recommendation for light duties as needed.

c. Medical report

Signature: ....................................................... Name: ..................................................... Clinician’s Stamp: Date: .......................................................

**\*\*\*\*The document must be stamped and signed by the DOH/DHA/MOH licensed clinician\*\*\***

**Clinical staff at National Ambulance may make contact for clarification of details**

**Occupational Health Referral – Part D**

To be completed by the NA Medical Director or Delegate

Occupational Health Referral Form received by:

Medical Director /Delegate…………………………………………… Date: ………………………………………………………

With reference to the above information regarding employee ………………………………………………………..,

Diagnosis…………………………………………………………………………………………………………………………………………..

Seen by (Clinician)…………………………………………………………………………………………………………………………….

Seen at (Facility)……………………………………………………………………………………………………………………………….

Treatment/Management Plan Summary…………………………………………………………………………………………..

…………………………………………………………………………………………………………………………………………………………

The National Ambulance Medical Director/Delegate recommends the following:

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Signature: ………………………………………………………………………

Date: ……………………………………………………………………………..

**All information is to be saved on the employee’s confidential OH personnel file and where relevant, in the HR file**