HEALTHBRIDGE REFERRAL FORM

Once form is completed please e-mail to: contact@healthbridge.org.uk

REFERRAL INFORMATION

REFERRAL TYPE

○ EMPLOYER REFERRAL

○ EMPLOYEE SELF REFERRAL

SERVICE REQUEST

○ FIT FOR ROLE ASSESSMENT

○ REASONABLE ADJUSTMENTS ADVICE

○ MENTAL HEALTH/NEURODIVERSITY REVIEW

○ RETURN TO WORK ASSESSMENT

○ SICKNESS ABSENCE REVIEW

REASON FOR REFERRAL

EMPLOYER DETAILS

COMPANY NAME

COMPANY ADDRESS

CONTACT DETAILS   PHONE _____   EMAIL _____

EMPLOYEE DETAILS

FULL NAME _____   **DATE OF BIRTH** _____

CONTACT DETAILS   PHONE _____   EMAIL _____

JOB TITLE/ROLE

WORK PATTERN (e.g. office, remote, hybrid)

CONSENT/DECLARATIONS (Employee to complete)

By signing this form, you confirm that you have read and understood the following, and that you consent to proceed with an Occupational Health assessment provided remotely by HealthBridge Occupational Health Ltd. You understand that this assessment is an advisory occupational health service and not a medical or legal opinion. The advice provided is intended to support workplace and wellbeing decisions only. HealthBridge, including Dr James Stanley, is not responsible for how this advice is used in any legal, disciplinary, or tribunal proceedings. You understand that an Occupational Health report may be prepared following the assessment. The report will be sent to you, the employee being assessed, for your review, and it will only be released to your employer if you give separate, explicit consent for its disclosure. The report will include relevant work-focused recommendations, but it will not contain personal medical details unless you give explicit, written permission for such information to be disclosed. You understand that all personal information you provide will be processed and stored confidentially, in line with HealthBridge's privacy and data protection policies, and handled in accordance with GDPR and statutory requirements. You acknowledge that your records will be retained in line with the standard medical records retention policy applicable to Occupational Health services.

Signature: _____   Date: _____