formhealth+
strategies for work and life

REFERRAL FORM

Should you have any questions or need assistance with completing this referral form, please do not hesitate to contact us on 0203 021 1735.

Once completed, please email to: Susan Smith (referral manager) - referrals@formhealth.com or Click the Submit button at the bottom of the document to automatically attach the completed form to an email.

YOUR REF:		DATE OF REFERRAL:	

YOUR CONTACT INFORMATION			
Name:		Phone:	
Company:		Email:	
Position:		Site/Address:	

INFORMATION ON INDIVIDUAL BEING REFERRED			
Name:		Home phone:	
Date of birth:		Mobile phone:	
Email:		Home address:	
(For insurers only) Policy type:	☐ Income protection ☐ TPD	☐ Employer's Liability ☐ Motor	☐ N/A ☐ Other
Nature of injury/diagnosis:		Date of onset:	
Current Treatment (if undertaken):			
Is the individual aware of the referral?		☐ Yes ☐ No	

SERVICE REQUIRED			
☐	Functional Capacity Evaluation (FCE)	☐	Whole Body
		☐	Upper Limb
		☐	Lower Limb
☐	Work Capacity Evaluation (WCE)	☐	Whole Body
		☐	Upper Limb
		☐	Lower Limb
☐	Functional Capacity and Cognitive Evaluation (FCCE)		
☐	Chronic Pain Abilities Determination (CPAD)		
☐	Absence Management Programme		
☐	Psychological Evaluation	☐	Cognitive Assessment
		☐	Mental Health Assessment
		☐	Neuropsychological Assessment
☐	Vocational Rehabilitation		
☐	Active Work Solutions (AWS)		
☐	Transferable Skills Analysis (TSA)		
☐	Vocational Exploration (including redeployment exploration)		
☐	Occupational Health Physician (OHP)		
☐	Ergonomic Assessment (EA)		
☐	Job Demands Analysis (JDA)		
☐	Dyslexia, Dyspraxia, and Dyscalculia Assessment		
☐	Work-focused Therapy	☐	Cognitive Behavioral Therapy
		☐	MSK
		☐	Functional restoration Program
		☐	Condition Management Program
		☐	Pain Management Program
☐	Independent Medical Examinations (IME)		
☐	Pre-Employment and Employment Screening		

☐	Medical Report Support Services	☐ Peer Review ☐ Forensic Review of Medical Records ☐ Second Opinion ☐ Evidence Gathering
☐	Diagnostics	☐ MRI ☐ X-ray ☐ CT ☐ Other
☐	Interventions and Minor Surgeries Please specify	
☐	Training and Education	☐ Stress Management in the Workplace ☐ Resilience ☐ Managing Cancer in the Workplace ☐ Sickness Absence Management ☐ Mental Health First Aid

SERVICE LOCATION REQUIRED	
☐	Individual's home
☐	Meeting room/Clinic
☐	Individual's workplace
☐	Other (please specify) -

OCCUPATIONAL INFORMATION	
Job title:	
Employer:	
Date first absent from work (if applicable)	

Additional employer contact details (If required)	Name:	
	Position:	
	Phone:	
	Email:	
	Site/Address:	

REASON FOR REFERRAL

ANY SPECIFIC INSTRUCTIONS

Please note, that as data processor, we will not be seeking additional consent from individuals referred for our services including in scenarios where a sub-processor may be utilised in order to fulfil service requests. We will however be contacting individuals (where we have been given permission to do so) to inform them of our proposed actions to provide services referred (including detailing any sub-processors that will be holding processing their data in order to do so) and ensuring individuals are aware of and have access to our Privacy Notice. Where we do not have permission to contact individual's directly, we request that the referring party ensure that the individual is aware of and has access to this information. A copy of our Privacy Policy can be gained via our website.