|  |
| --- |
| READ THIS CAREFULLY BEFORE COMPLETING THIS FORM This form is to be completed by the **authorised referring manager / responsible person** unless otherwise indicated. Please complete this form and return it directly to the University of Nottingham Occupational Health Department, Cripps Health Centre, University Park, Nottingham NG7 2QW or alternatively email to [BR-Occ-Health@nottingham.ac.uk](mailto:BR-Occ-Health@nottingham.ac.uk) |

|  |  |
| --- | --- |
| 1. **Contact Details**   **For completion by Referring Manager / Responsible Person. Note: The completed report will be provided to this person** | |
| Your Name Mr/Mrs/Ms/Miss/Dr (BLOCK CAPITALS PLEASE)  Contact Tel No Faculty ………………………………………………………….  School / Dept Division (if appropriate)………………………………………..  E-mail address………………………………………………. Address for us to replyto……………………………………. ……………………………………………………………………………………………………………………………………….. | |

1. **Please tick the appropriate box and complete section 2a or 2b**

**I am referring a department I am referring an individual**

**2a. Department information**

|  |
| --- |
| Department requiring surveillance………………………………………No of persons requiring surveillance...........................  .Is there a shift pattern affecting any of these persons? Y / N Please provide details...........................................................  If No please state department start and finish times...............................................................................................................  **Surveillance is held in the OH Department unless otherwise specified.** If an alternative surveillance location is required please provide exact details: |

**2b. Individual information**

|  |
| --- |
| Name of referred individual……………………………………………………………………………………….………………..  Date of Birth…………….………..…Payroll No ………………….Contact No for Individual Home……………………………  Address of Individual………………………………………………………………………………………………………………..  Job / role of Individual……………………………………Campus/Location of Individual….…………………………………. |

**2. Health Surveillance Requirements**

For completion by Referring Manager / Responsible Person

|  |  |  |  |
| --- | --- | --- | --- |
| **Tick box** | **Number of individuals requiring this aspect of surveillance** | **Aspects of statutory surveillance / assessment required** | **Reason this would be required** |
|  |  | Audiology | Exposure to 80dB(A) TWA or significant impact noise |
|  |  | COSHH Respiratory | Exposure to COSHH Respiratory sensitizers or RSC above the WEL |
|  |  | COSHH Dermatology | Exposure to COSHH Skin sensitizers |
|  |  | HAVS | Exposed to HTV exceeding 2.5m2 |
|  |  | RPE Fit testing | A tight fitting (none air fed) mask is a mandatory requirement in role |
| **Tick box** | **Number of individuals requiring this aspect of surveillance** | **Aspects of non-statutory surveillance or fitness for task assessment required** | **Reason this would be required** |
|  |  | Manual handling | Significant MH activities or repetitive tasks |
|  |  | Night Time Workers | Employees work 3 or more hours between 11pm and 6am on a regular basis |
|  |  | Site vehicle driving (includes eye sight) | Drives university vehicle which does not go on a public highway |
|  |  | Confined space assessment | Required to access confined spaces |
|  |  | Working at heights | Required to work at heights |
|  |  | Lone worker | Required to work alone |
|  |  | Visual assessment | Safety critical activity relative to vision |
|  |  | Other | Please state............................................................................... |

University Project code for recharge (if applicable)…………………………………………………………...

# Signed …………………………………….…….. Name……………………………………………. Date……………

**Referring Manager / Responsible Person**