

**SELF REFERRAL FORM**

Occupational Health Nurses and Doctors can assess and advice about health issues either caused or made worse by work or where your health is adversely affecting your work. We do not offer a GP or treatment service for common illnesses or non-work-related injury so it is vital you are registered with a GP. If you are unwell you should see your own GP or attend an NHS walk-in centre or in medical emergencies only, the Accident & Emergency Department.

All Self referrals are triaged by an experienced Occupational Health Nurse Advisor who will allocate your referral to the most appropriate clinic. Appointments with a nurse are usually offered within 5 workings days and those with a doctor within 10 working days. More urgent cases such as inoculation injuries and transmissible infections will be seen as a priority and do not need to complete this form.

We recommend that for any health issues which are impacting on work that you raise these with your line manager before self referring to Occupational Health

**Once completed Send back to:** [**esth.occhealth@nhs.net**](mailto:esth.occhealth@nhs.net) **or post to Occupational Health Department, Epsom and St Helier Hospital, Ground Floor G Block, Wrythe Lane, Carshalton Surrey, SM5 1AA Contact Number 020 8296 2678**.

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| **ABOUT YOU** | | |
| **Surname:-** | **First Name:** | |
| **Home Address:-** | **Date of Birth:** | |
| **Contact Telephone Number:** | |
| **Email Address:-** | **Name of your department you work in** |  |
| **Full Job Title (No Abbreviations):-** | **Name of your Division you work in** |  |
| **Site:-Epsom/St Helier/** |  |  |
| **Employer:-** | **Staff Bank** |  |
| **Epsom & St Helier Hospital Trust** | **EOC** |  |
|  | **Renal Services** |  |
| **Specific Department:-** | **Other (please state)** | |
| **About Your Health Issue/Concern** | | |
| **Briefly tell us about your problem/concern:-** | | |
| **How does it affect you at work?**  **If it impacts on your work have you discussed with your line Manager?** | | |
| **How severe is it? Mild Moderate Severe**  x | | |
| **How long have you has the problem? No of days/ Weeks (delete)** | | |
| **Please give us any other relevant information that will help us allocate an appointment** | | |
| **For OH USE ONLY:- Triage Outcome**:  **Work for Health Triage Call** **Work for Health Appt OHA** **Work for Health OHP**  **Other** | | |