**Form 1 - Agency Referral for Medical Services**

**Service Providers**

This form is part of the Agency Agreement (Standard Form of Agreement) and incorporates all parts, terms and conditions and other documents listed in clause 2 of the Agency Agreement as if repeated in full in this Agency Referral for Medical Services form.

This form may only be modified with agreement of the Principal/Agency.

**Agencies**

The following form must be completed by Agencies when referring an employee to a Service Provider on the *Prequalification Scheme: Employment Related Medical Services* for any of the following services:

* Medical assessments
* Administrative support to the Review Panel
* Validation of medical certificate
* Pre-employment and periodic employee health assessment
* Other employment related medical services, including:
* Functional capacity assessment and advice services
* Vaccinations
* Blood and alcohol testing
* Employee health and wellbeing programs

A list of prequalified Service Providers on the *Prequalification Scheme: Employment Related Medical Services* available on the NSW Government [Buy.nsw.gov.au](https://buy.nsw.gov.au/schemes/employment-related-medical-services-scheme).



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| Please complete **ALL** of Parts A, B, and C, and Part D, where applicable.The agency head or authorised delegate must sign this form and any written report. Incomplete forms will be returned to agencies.**Submitting the request** Please email this form to [name of Service Provider] at [insert Service Provider email address]**Cancelling the request** Please advise [name of Service Provider] directly on [phone contact of Service Provider] or [email address of Service Provider] to cancel a referral request. A cancellation fee may apply |

**Part A: Service requested**

A description of the services is available in Schedule 2 of the Scheme Conditions

Place a ☒ in the relevant box(es)

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| [ ]  **Medical assessment** Please complete Part D |
| [ ]  **Review of medical assessment by the independent Review Panel**. * Employee’s Request for Review of Medical Assessment form (Form 4) and all relevant medical documents are attached;

OR* Employee’s Request for Review of Medical Assessment form (Form 4) is attached, all relevant medical documents will be provided shortly.
 |
| [ ]  **Medical Certificate Validation** (Please attach employee’s leave application, medical certificate and consent to release medical information) |
| [ ]  **Pre-placement** or **Periodic Health Assessment** Please attach inherent role requirements and demands. |
|  [ ]  a. Standard health assessment; or  |
|  [ ]  b. Standard health assessment with additional service options (specify):  *Specify additional pre-placement/periodic requirements*  |
|  [ ]  c. The potential employee’s signed health declaration (attached) indicates they are aware of a health condition which may have an impact on their ability to perform the inherent requirements and demands of the role. |
|  [ ]  d. The inherent job requirements refer specifically to essential role requirements and demands e.g. physical, sensory and psychological capacities or contact with physical, biological and chemical hazards. |
| [ ]  5. Other optional health services negotiated with service provider (specify):  *Specify service requirements* |

**Part B: Employee/Potential Employee to be assessed**

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| **Last name Given name(s) Date of birth:**

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**Former name (if applicable) Gender Employee number**

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|       |  |  [ ]  Male [ ]  Female[ ]  Other |  |       |

**Work address Work phone Work email**

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**Home address Home phone Home email**

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**Role title Mobile phone**

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**Interpreter required If ‘Yes’, what language**

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| --- | --- | --- |
| [ ]  Yes [ ]  No |  |       |

**If a current employee:****Is employee currently on duty? Date employee started in their substantive position**

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| [ ]  Yes [ ]  No |  |       |

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**Part C: Agency details**

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| **Cluster Department**

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**Agency**

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**Agency contact** *(for information / results / report)* **Contact’s position title**

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**Address Phone / Mobile Email**

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**Service Provider**

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**Name of Service Provider contact person and position**

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**Contact phone and email:** **Phone / Mobile Email**

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**Part D: Checklist for medical assessment**

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| [ ]  | Basis for referral  |
| [ ]  | Description of inherent requirements and demands of the position |
| [ ]  | Outline the health-related issue(s) that is/are affecting the ability to perform the inherent requirement/s and demands of the position (including sick leave records and recent medical certificates) |
| [ ]  | Specific question(s) |
| [ ]  | Agency proposals  |
| [ ]  | Previous referrals |
| [ ]  | Confirmation that referral is for a non-work related health issue |

**Authorisation (Agency Head or authorised delegate)**

**Name Role title Date**

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**Signature**

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