**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:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  |   **Former name (if applicable) Gender Employee number**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  | Male  Female  Other |  |  |   **Work address Work phone Work email**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  |   **Home address Home phone Home email**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  |   **Role title Mobile phone**   |  |  |  | | --- | --- | --- | |  |  |  |   **Interpreter required If ‘Yes’, what language**   |  |  |  | | --- | --- | --- | | Yes  No |  |  |   **If a current employee:**  **Is employee currently on duty? Date employee started in their substantive position**   |  |  |  | | --- | --- | --- | | Yes  No |  |  | |

**Part C: Agency details**

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| **Cluster Department**   |  | | --- | |  |   **Agency**   |  | | --- | |  |   **Agency contact** *(for information / results / report)* **Contact’s position title**   |  |  |  | | --- | --- | --- | |  |  |  |   **Address Phone / Mobile Email**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  |   **Service Provider**   |  |  | | --- | --- | |  |  |   **Name of Service Provider contact person and position**   |  | | --- | |  |   **Contact phone and email:**  **Phone / Mobile Email**   |  |  |  | | --- | --- | --- | |  |  |  | |

**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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