Eastern Health

Workplace Health, Safety and EFAP

ERGONOMIC INJURY PREVENTION REFERRAL

Date: DD/MONTH/YYYY Worksite:

Program/Dept.:

If this is related to an individual employee assessment please complete the following:

Employee's Name: **Date of Birth:** DD/MONTH/YYYY

Employee Number: **Telephone Number:**

Job Title / Classification:

Manager's Name: Telephone Number:

Referred By:

- ☐ Disability Manager - Name:
- ☐ Manager
- ☐ Employee (Self)
- ☐ Regional Ergonomics Program Coordinator
- ☐ Workplace Safety - Name:
- ☐ Other:

Reason for Referral:

- ☐ Individual Computer/Office Workstation Review (Completed Self-Assessment Form MUST be included)
- ☐ Individual Non Office Workstation Review
- ☐ Ergonomic Assessment - Group Work Area
- ☐ Follow up assessment (explain below)
- ☐ Work Environment Redesign / New Design (explain below).
- ☐ Product / Equipment Evaluation
- ☐ Safe Patient/Resident Handling Consultation
- ☐ Education/Training (explain below)
- ☐ Job Site Analysis

Please indicate if:

- ☐ Referral is related to a Service NL Directive ***(Directive must be attached)***
- ☐ Referral is related to a tender

Please provide any additional information which you feel may be of benefit:

Please email all Referral Forms to
ergonomics@easternhealth.ca

If you have any questions please contact 777-7777, x.3, x.2

The personal information is being collected under the authority of Sections 29, 30 and 31 of the Personal Health Information Act and will be used for assisting employee's with return to work, accommodations at work and/or medical issues affecting their ability to work. If you have questions concerning the collection, use, and disclosure of this information, please contact the Workplace Health, Safety and EFAP Program . If you have questions relating to Privacy and Access, please contact 777-8025.