Referral to Homewood Health

Complete the form to the best of your abilities, then return to recovery@ualberta.ca. Completion of this form will involve Homewood Health.

Check (☒) Reason for Referral: **IMPORTANT – selecting the correct Service Type will avoid delays**		
☒	**HHI Service Type**	**Description of Service**
☐	**Medical Leave/General Illness (Short Term Disability)**	Staff Members who are **off work** for medical reasons, performing modified work (hours and/or duties), or have a future-dated scheduled medical procedure.
☐	**Absence Management**	Review required to determine whether or not recurring absences are medically supported. If applicable, confirmation of restrictions/limitations, and/or recommended accommodation(s)
☐	**Accommodation Review**	Review required to determine if a request for accommodation (**that is not a request for modified hours and/or duties**) is medically supported. If applicable, confirmation of restrictions/limitations, and/or recommended accommodation(s)
☐	**DM at Work**	Assistance to remain at work i.e., Support to staff members who are **at work doing full duties and hours**, who do not require STD, Absence Management or Accommodation Review services.

Manager/Supervisor Information	**HRS Information**
Manager/Supervisor Name:	HRP Contact Name:
Manager/Supervisor Email:	HRP Primary Phone:
Title:	HRP Email:
Faculty:	HRP Alternate Phone:
Department:	Next Level Management Supervisor:

Employee Information	
Last Name:	First Name:
Employee ID:	Preferred Pronoun: ☐ She/Her ☐ He/His ☐ They/Their ☐ Prefer not to specify ☐ Pronoun other than listed
Primary Phone:	Work Email:
Preferred Language:	Date of Birth:
Address *(optional)*: City:	Province: Postal Code:

Association: ☐ Academic ☐ Support ☐ Excluded ☐ MAPS ☐Other	Job Standard Hours:
Faculty:	Dept ID:
Job Title:	Safety Sensitive? ☐ Yes ☐ No
Salary: ☐ Hourly ☐ Salaried	Salary/Hourly Wage:
Staff member's regular work schedule:	
Benefit Hours Remaining:	
Information Concerning the Staff Member's Absence	
Do you require a call from the Health Support Consultant prior to contacting the staff member? ☐YES ☐NO	Date of Illness/Injury:
First Day Absent or First Day of Modified Work:	Last Day Worked Full Time/Full Duties *(Leave blank if the staff member is currently working full hours / duties)*:
Current Work Status: ☐Not At Work ☐At Work Full Time/Full Duties ☐At Work Modified Duties ☐At Work Upcoming Absence	