

# CONSENT FORM – THIRD PARTY REFERRALS



YOUR PERSONAL DETAILS – PLEASE COMPLETE IN BLOCK CAPITALS

YOUR FULL NAME			
YOUR ADDRESS:			
		POSTCODE:	
MOBILE NUMBER:		DATE OF BIRTH:	
PERSONAL EMAIL:			

Please note:

- Please ensure all details above are correct and complete
- Failure to complete this form will invalidate consent.
- We will only forward copies of reports to private email addresses. If the email address is not provided above or if given, is in doubt or unreadable please note that this will result in correspondence being sent by post and we will only send to the address provided above.
- We require a consent form to be completed for each consultation. This form supersedes all others.

NAME OF EMPLOYER / EMPLOYER REPRESENTATIVE:	
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## CONSENT FOR CONSULTATIONS AND REPORTS

I, the Employee ("I", "me" or "you" as referred to in this document), confirm that I have been informed by my employer/employer representative of the purpose of, and I have agreed to take part in, this occupational health referral, which includes onward referral to the ancillary service provider detailed below.

I understand that my personal data (including my health data) will be shared with the third parties as indicated below.

### Ancillary Service Provider:

Company Name:			
Company Address:			
	Post Code		
Service Required:	<input type="checkbox"/> Counselling <input type="checkbox"/> DSE/Workstation Assessment/Workplace Assessment <input type="checkbox"/> Dyslexia Assessment <input type="checkbox"/> Ergonomic Assessment <input type="checkbox"/> Occupational Health <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Other (please detail):		

Although consent for the processing of personal data is required, in certain circumstances, if Medigold Health are advised by your employer/employer representative that your role is safety critical or become aware that my continued performance of your working role will endanger the safety and well-being of yourself and others, Medigold Health will send my employer/employer representative a statement of fitness to advise what restrictions should be placed on my working role or my fitness to undertake that role.

It is your responsibility, if required, to advise (or provide a copy to) any Licencing Authority or organisation (such as the DVLA) of the outcome of this medical. If requested by a Licencing Authority or organisation, Medigold Health will provide a copy of the outcome report.

## CONSENT FOR CONSULTATIONS / MEDICALS AND REPORTS

If a face to face consultation is being requested I understand that this consultation might incorporate a physical examination and such additional tests may be necessary, the nature of which will be explained to me. I understand that this referral may incorporate more than one session in order to complete the assessment or treatment.

I understand that the above will provide documentation including but not limited to a report, assessment report, outcome or test results to Medigold Health.

I understand that in being referred via Medigold Health for additional service provision by the third party above, copies of any documentation generated will be provided to Medigold Health and will form part of my occupational health records. I understand that the report provided by the above to Medigold Health may include outcomes, recommendations or adjustments.

### Report

I hereby agree to a report being provided to my employer/employer representative on the basis of the medical information received from the above by Medigold Health Consultancy Limited (Company number: 03507491) a company registered at Medigold House, Queensbridge, Northampton NN4 7BF (or its group companies, subsidiaries or appointed representatives, including medical practitioner's acting on its behalf) ("Medigold Health"), including any written or verbal information that I have provided for Medigold Health, or any information received by Medigold Health from other health practitioners.

I understand that any report will include appropriate information and recommendations about my medical condition(s) in relation to my current and potential future fitness for work. I understand that copies of any documentation generated by Medigold Health's subsidiaries or appointed representatives will be provided to Medigold Health, to form part of my occupational health records.

A copy of the report will be automatically despatched at the same time to me and my employer/employer representative unless I request otherwise. I understand the report will be despatched to me by password protected email, unless I indicate otherwise or fail to provide a private email address. I understand that if I wish to receive a copy of the report prior to my employer/employer representative, I must inform Medigold Health within 24 hours of the consultation date/time in writing to [consent@medigold-health.com](mailto:consent@medigold-health.com).

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I understand that if I have requested a copy of the report prior to my employer/employer representative, the report will be automatically despatched to my employer/employer representative three working days after the report has been despatched to me, unless I indicate otherwise within the two working days, by email, at which time your employer will be informed the report release will be delayed. If I have not provided a personal email, and the report is despatched by post, the report will be automatically despatched to my employer/employer representative four working days after the report has been posted to me, unless I indicate otherwise within three working days.

Responses to any additional queries raised by my employer/employer representative will be provided in accordance with this consent. I understand that if I provide additional information related to this referral of the subsequent report this will be processed in accordance with this consent

**By signing below, I understand that in agreeing to this occupational health referral my personal data will be processed in accordance with this form and the Privacy Notice, as set out on our website on [www.medigold-health.com/privacynotice/](http://www.medigold-health.com/privacynotice/). This form supersedes all others.**

Signature : X \_\_\_\_\_ Date: X \_\_\_\_\_  
(Facsimile of signatures are acceptable, typed signatures are not)