**TRAINEE REFERRAL FORM**

To ensure an appropriate and prompt follow up to your referral is made please complete all sections of the referral form

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| 1. **Trainee Core Data**
 |
| **Trainee Name** |  | **GMC/GDC****Number** |  |
| **Email Address** |  | **Mobile Number** |  |
| **Specialty** |  | **Stage of Training** |  |
| 1. **Fitness to Practice and Safety Concerns**
 |
| Do you have concerns about this trainees’ fitness to practice? | Y | N |
| Do you have concerns about the safety of the following (tick all that apply) |
| Patients (receiving treatment from the trainee) | The trainee  | Colleagues/Relatives/Carers (of the trainee) |
| 1. **Level of Concern (refer to the PSU guidance**
 |
| Level 1 | Level 2 | Level 3 |
| 1. **Type of Concern (Tick all that apply)**
 |
| Clinical Performance  |  | Health Issues |  |
| Personal Conduct (Personality/Behavioural/Professionalism) |  | Communication/Team Working/Time Management |  |
| Significant Life Event |  | Environmental Issues (inappropriate workload/poor culture) |  |
| Exam Failure |  | Professional Conduct (e.g. Probity) |  |
| Other (please specify) |
| 1. **Please provide your reasons for the concerns you have about this trainee and attach any relevant supporting documentation which you think will be useful**

**(MSF Summary for example). If referring for exam concern please state number of attempts**  |
|  |
| 1. **Please indicate the actions/support/intervention which have already taken place**

 **If you wish to provide further detail please use the box below** |
| Occupational Health Referral  |  | Repeat MSF/TAB |  |
| Additional Supervision / Mentoring |  | Instigation of Formal Policies/Procedures at local level |  |
| Other (please specify).  |
| 1. **Referral Made By**
 |
| **This referral should be discussed with the trainee, the Head of School or STC Chair or TPD and the Clinical Tutor. If you have not discussed this referral with any of those named above, please state who the referral has not been discussed with and the reason why:** |
| **Name** |  | **Email Address** |  |
| **Professional Relationship with trainee referred** |  |
| **Signature (required if not been sent from your NHS email account)** |  |
| **Date** |  |

Completed forms must be returned to psu.wm@hee.nhs.uk