KAISER PERMANENTE

Occupational Health and Safety Services - County of Sonoma Referral Form

Please complete and fax this form to the clinic location where services are to be provided. To inquire about appointment availability or to change or cancel an appointment, please call the Occupational Health Clinic and ask for the OHSS service representative or a clinic staff member.

Kaiser Contact Phone: Cris Rico 566-5654 Kaiser FAX: 566-5536 Clinic Location: Santa Rosa

Name of Department Contact for Results/Questions: _____ Date: _____

Dept. Contact Phone: _____ Department FAX: _____

Candidate/Employee Name: _____ Kaiser MR# _____

If Kaiser MR# not available, please provide the following:

Candidate/Employee Address: _____

Home/Cell Phone: _____ Work Phone: _____

SS# (last 4 digits only): _____ Date of Birth: _____ Gender: ____Male ____Female

Maiden Name (when applicable): _____

SERVICES REQUESTED

Pre-Placement Services	Other
Job Title: _____	____ Respirator Clearance (RESP)
____ Preplacement Exam (PPE)	____ HazMat (HAZ) – Emergency Services
PPE Type: Select PPE Type (if applicable)	____ Bomb Squad
____ Drug Screen	____ DMV Physical (DMV)
____ TB Screen	____ PPD Annual – TB Clearance
____ Candidate has also been scheduled for abilities testing at FUTURES REHAB on (date): _____	____ Audiogram
____ ATD Screen	____ Fitness for Duty (FFD/RTW) *(Contact KOJ Office for instructions/ protocols).* FFD/RTW Includes: ____Drug Screen ____Breath Alcohol Test

Vaccinations

____MMR ____Varivax ____Hep B ____Tdap ____Influenza ____Other_____

APPOINTMENT DETAILS

Comments/Additional Services Requested: _____

Preferred Date/Timeframe for Appt: _____

Appt Scheduled for: _____