KAISER PERMANENTE

Occupational Health and Safety Services
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.

Clinic Location: **Santa Rosa** Date: _____

Phone: **Cris Rico** 707-566-5654 Fax: 707-566-5536

Company Name: **County of Sonoma**

Department: _____

Company Contact for results/questions: _____

Phone: _____ Fax: _____

Employee Name: _____ Kaiser MR# _____

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

Address: _____

Home Phone: _____ Work Phone: _____

SS#: *(last 4 digits only)* _____ Date of Birth: _____

Maiden Name (when applicable) _____

Gender: ☐ Male ☐ Female Job Title: _____

Services Requested

Preplacement Services	Non-Preplacement Services
____ Preplacement Exam (PP1) ____ Futures Job Title: _____ ____ Preplacement Exam (PP2) for Juvenile Correctional Counselor DA Investigator/Deputy Sheriff/Correctional Deputy ____ Preplacement Police Officer (POSTPP) ____ Drug Screen ____ w/o Drug Screen ____ Volunteer Firefighter (Emergency Services) ____ TB Testing ____ w/o TB Testing	____ Respirator Clearance (RESP) ____ HazMat (HAZ)- Emergency Services ____ Bomb Squad ____ Fitness for Duty (FFD/RTW) (contact KOJ office for instructions/protocols) w/ ____ Drug Screen ____ Breath Alcohol Test ____ DMV Physical (DMV) ____ PPD annual – TB clearance ____ Audiogram ____ Futures ____ Vaccination ____ **MMR** ____ **Varivax** ____ **Hepatitis B** ____ **Tdap** ____ **Influenza**

Other services may be provided and billed at the physician/clinician's discretion to give clearance on an applicant/employee as identified in your Letter of Agreement (LOA) under the "As Clinically Indicated" section of that visit category. If other screening/testing is needed and is not outlined in the LOA, we will call for authorization.

Preferred date and/or timeframe for appointment: _____

APPT IS SCHEDULED FOR: _____

Comments/Additional Requests: _____

For clinic use only:

1st attempt for notification to employee:	**Date:**	**Time:**	**Initials:**
2nd attempt for notification to employee:	**Date:**	**Time:**	**Initials:**
3rd attempt for notification to employee:	**Date:**	**Time:**	**Initials:**