Occupational Health and Safety Services
Referral Form

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

Employee should arrive at least 30 minutes early for their exam, and must bring the following:

- *Government-issued ID (i.e., Driver's License, Real ID, passport)*
- *All immunization records, if applicable and available*
- *TB Test records, if applicable and available*
- *Eyeglasses/contacts/corrective wear (if applicable)*
- *Hearing aid (if applicable)*

Clinic Location: Kaiser - Santa Rosa Date: _____

Phone: 707-766-5550 Fax or Email: 707-566-5536 SRO-OHS@kp.org

Company Name: RESIG/Redwood Empire School Insurance Group

Guarantor Name/Number (Internal Use): **326000000095**

Company Contact for results/questions: Suzanne Pelz

Phone: Suzanne: (707) 836-0779 x134

Fax or Email: 707-836-8374(RESIG) MEMBER Fax or Email: _____

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: _____

Other Name(s) used (when applicable) _____

Gender: ☐Male ☐Female ☐Non-binary Job Title: _____

Services Requested

Preplacement Services:

ATTENTION: A job description is required at the time of the exam, unless previously submitted, to avoid a delay in medical clearance.

☑ **(PP1)**

Standard Service(s): Pre-placement Exam

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.

SCHEDULE APPOINTMENT WITH: ☐Applicant/Employee (and notify employer) ☐Employer

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:**