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: ____________________ Date: ____________________

Phone: ____________________ Fax: ____________________

Company Name: **Foothill De Anza Community College District**

Department/Location: ____________________

Company Contact for results/questions: Christine Vo

Phone: (650) 949-6224 Fax: (650) 949-6299

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

Non Preplacement Services:

___ **Evaluate Work-Related Injury**

Date of Injury: ____________________ **Last Work Day:** ____________________

Injured Body Part: ____________________

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:**