Clear Form

Heraya
SMART SOLUTIONS. HEALTHY RESULTS.

Kaiser On-the-Job Initial Treatment Plan

Treating Heraya Provider: _____ KP Attending Physician: _____

Phone: _____ Patient Name: _____

Fax: _____ Kaiser I.D. #: _____

Work Status:

Medications:

History:

Subjective Reports:

Objective findings:

Diagnosis (must be consistent with the diagnosis noted on the referral):

Treatment Plan (consistent with KP referral):
Visits:_____ Duration: Start Date_____ End Date:_____
Modalities:

Measureable Goals (work capacity, pain scale, OATs)

Heraya Provider Signature:_____ Date:_____

KP Attending Physician Signature:_____ Date:_____

Forward to the Kaiser Permanente Occupational Health Department via fax at 866-599-3561
Questions about referrals should be directed to 503-735-7443