



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
