

Intake Form (Family Member)



1. Information to care for a family member

Today's date:	Family member date of birth:	Kaiser Permanente ID number:
Patient's name:		Patient phone #:
Requestor's name: _____	Patient is my: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other	
Requestor phone #: _____	Describe care you will provide to patient and estimated duration: _____	
Mailing address: _____		

2. Method of Form Delivery

Has the patient signed an Authorization to Disclose Health Care Information form? Yes No (If no, see a Patient Access Representative)

In-person pick-up (Specify name if someone other than patient is authorized to pick up): _____

By fax (Recipient name and fax #): _____ By mail By MyChart/online (FMLA requests only)

3. About the Patient's Condition

Name of Kaiser Permanente clinician seeing the patient: _____

Brief description of the condition, injury or diagnosis: _____

Was the patient in the hospital? No Yes If Yes, what dates? _____

4. Request Type

Is this a FMLA request? Yes If yes, continue below No If no, specify request type: _____

Has the patient been seen for this condition at least 2 times? Yes No (If no, patient needs to schedule office visit)

5. Work Status History (FMLA request only)

Employer name:	Employer contact:
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6. Estimated Leave Time (FMLA request only)

<input type="checkbox"/> Continuous Leave: Patient is unable to work for a single continuous period of time Estimate period of inability: Start Date _____ End Date _____	<input type="checkbox"/> Follow-Up Treatment Leave: Patient needs follow-up care and time for recovery <input type="checkbox"/> Intermittent Leave: Patient needs occasional time off for recovery Estimate hours/days the patient needs care: # hours per day _____ # days per week _____ Start Date _____ End Date _____	<input type="checkbox"/> Episodic Leave: Condition causes occasional flare-ups Estimate frequency and duration over the next 6 months to care for patient flare-ups: Frequency: _____ times per _____ week(s) per _____ month(s) Duration: _____ hours or _____ day(s) per episode
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Please note: Certified time off will be based on medical need and may be different than the time requested.

Forms Processing Acknowledgment

- This acknowledgment must be signed by the patient, parent, legal guardian, or person with legal power of attorney prior to the completed form being picked up, mailed, or faxed.
- Kaiser Permanente Washington requires up to ten (10) days for processing all forms.

I have read, understand, and agree to the above forms processing acknowledgment statements

Signature of parent, legal guardian, or person with legal power of attorney

Date

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BUSINESS OPERATIONS USE ONLY



Clinician to complete form: _____

Special instructions to clinician: _____

Special instructions to Business Office staff: _____

Request received by: _____

If the form is being mailed/faxed to a third party, has an Authorization to Disclose (Release) Health Care Information form been completed? Yes No

If the Authorization to Disclose (Release) Health Care Information form is not required, has this Intake form been signed by the patient? Yes No