Intake Form

KAISER PERMANENTE®

1. Patient Information

Today's date:	Patient date of birth:	Kaiser Permanente ID number:
Patient's name:		Patient phone #:
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 an 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, schedule office visit)*

5. Work Status History (FMLA request only)

Employer name:	Employer contact:
Patient's job title:	Regular work schedule:
Describe patient's job functions:	

6. Estimated Leave Time (FMLA request only)

□ **Continuous Leave:**	□ **Follow-Up Treatment Leave:**	□ **Episodic Leave:**
Patient is unable to work for a single continuous period of time	**Patient needs scheduled follow-up care and/or reduced work hours**	**Condition causes occasional flare-ups**
Estimate period of inability: Start date _____ End date _____	Estimate follow-up care and/or reduced work hours: # hours per day _____ # days per week _____ Start date _____ End date _____	Estimate frequency and duration of flare-ups over the next 6 months: **Frequency:** _____ times per ____ week(s) per ____ month(s) **Duration:** _____ hours **or** _____ day(s) per episode

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 patient, 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**