KAISER PERMANENTE®

Release of Information Department
10220 SE Sunnyside Road, Clackamas, Oregon 97015-9764
Phone: (503) 571-5051, Fax: (503) 571-2624

FORM COMPLETION REQUEST (Disability/FMLA)

ROI Intake Initials___________

Patient Information

Today's Date:	Patient Health Record Number:
Patient's Full Name:	Email Address (Ok to send to shared address) YES ☐ NO ☐
Home phone #:	Date of Birth:
Mailing address: Street/City/State/Zip:	Ok to leave detailed phone message? YES ☐ NO ☐ ________________________________ (Patient approval/signature required)

☐ Are you requesting information related to care for a family member? If yes, please include the following:

Your Name:________________________ Relationship to Patient: ____________________ Your Phone #:____________________

NOTE: Please attach an authorization to release medical information signed by the patient

Method of Form Delivery

☐ Email to: Name and e-mail address:____
☐ Pick up at Release of Information Department: ____________________________________
☐ Mail to Patient's Address:____
☐ Fax: (Please include name of recipient and fax number):_____________________________

About Your Condition

Date of onset of condition or injury: (mm/dd/yyyy)	Clinician Authorizing Time Loss:

Describe condition, injury or diagnosis:

Work Status History/Time Loss Due to Injury/ Intermittent Estimated Time Loss

Employer Name: ________________________________	What is your job title and job function:______________________ ☐ Mostly sitting (sedentary) ☐ Physical (walking. standing, lifting)
IN THE LAST 3 MONTHS: Provide an estimate of how much time loss the patient/family member has needed for this condition:	Total # of Days________________ Total # of Hours________________

Please select: ☐ This is a recertification ☐ This is NEW request

Please provide an estimate of time loss needed (Example :3 episodes/month, 2 days/episode for 6 months & start date)

Start Date: ________ - ________ - ________ ☐ **3 months** ☐ **6 months** ☐ **Other______ Months**

Number of Episodes per Month ____________ **Number of Days per Episode________________**

How many appointments will be needed to address this condition? At 0-4 hours per appointment:________________

Continuous Modified Duty Reduced Hrs

Select all that apply in relation to this condition:

☐ **Continuous time loss**	☐ **Modified Duty** (lift, stand, sit, etc.)	☐ **Reduce Daily Work Hours**
Start Date:____________	Start Date:____________	# of hours per day:________________
Return to regular work date:____________	Return to regular work date:________________	# of days per week:________________
		Start Date:________________
		Return to regular work date:_________

Temporary /Long Term Disability

☐ Temporary Disability (Recovery is expected) Start Date thru End Date:___________________________
☐ Long Term Disability (Patient is not expected to recover/improve) Start Date:____________________