Intake Form (Family Member)

KAISER PERMANENTE®

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: _____

Requestor phone #: _____

Mailing address: _____

Patient is my: □ **Spouse** □**Parent** □**Child** □**Other**

Describe care you will provide to patient and estimated duration:

_____

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:* _____

Is this a WA PFML 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 and WA PFML requests only)

Employer name:	Employer contact:

6. Estimated Leave Time (FMLA and WA PFML requests only)

□ **Continuous Leave:**
Patient is unable to work for a single continuous period of time

Estimate period of inability:
Start Date _____
End Date _____

□ **Follow-Up Treatment Leave:**
Patient needs follow-up care and time for recovery

□ **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 _____

□ **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

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

[redacted]

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