

## Division of Multiple Sclerosis and Neuroimmunology

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### MEDICAL FORMS INTAKE SHEET

- Please note that the patient must complete this intake form and all Patient Information sections of the form before the Provider will complete the Medical Provider section.
- All forms will be completed by the Provider within 10 (ten) business days after the form is received in full.
- If this form is not completed in its entirety, it will be returned prior to completion \*(Policy effective as of March 1, 2021)

PATIENT NAME: \_\_\_\_\_ PATIENT DOB: \_\_\_\_\_

PATIENT PHONE NUMBER: (    )\_\_\_\_-\_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_

PATIENT E-MAIL: \_\_\_\_\_

PATIENT'S PROVIDER: \_\_\_\_\_

DATE FORM(S) ARE NEEDED BY: \_\_\_\_\_

TYPE OF FORM TO BE COMPLETED (Please check):

*MOTOR VEHICLE*      *FMLA, DISABILITY, OR OTHER WORK-RELATED*      *OTHER:* \_\_\_\_\_

PURPOSE OF FORM: \_\_\_\_\_

TO WHOM SHOULD THE FORM BE RETURNED (Please check):

PATIENT      OTHER: NAME: \_\_\_\_\_

PHONE: (    )\_\_\_\_-\_\_\_\_\_      FAX: (    )\_\_\_\_-\_\_\_\_\_

ADDRESS: \_\_\_\_\_

E-MAIL: \_\_\_\_\_



FOR **MOTOR VEHICLE** FORMS:

**TYPE OF PARKING PLACARD BEING REQUESTED (Please Check):**  TEMPORARY  PERMANENT  NONE

PLEASE DESCRIBE ANY DISABILITY THAT REQUIRES PRIORITY PARKING: \_\_\_\_\_

\_\_\_\_\_

PLEASE DESCRIBE ANY CURRENT DRIVING IMPAIRMENTS: \_\_\_\_\_

\_\_\_\_\_

FOR **FMLA, DISABILITY, OR OTHER WORK-RELATED** FORMS:

PLEASE DESCRIBE YOUR CURRENT DAILY JOB ACTIVITIES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE EXPLAIN WHAT JOB ACTIVITIES YOU ARE UNABLE TO DO OR LIMITED IN DOING BECAUSE OF YOUR CONDITION. **BE SPECIFIC ABOUT LIMITATIONS** (I.E. HOW MANY MINUTES/HOURS CAN YOU DO CERTAIN ACTIVITIES, WHAT STOPS YOU FROM CONTINUING, WHY CANNOT COMPLETE THE ACTIVITY, ETC):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE LEAVE BEGAN/WILL BEGIN: \_\_\_\_\_  No Date, Possible, Future, Intermittent.

ANTICIPATED DATE OF RETURN TO WORK: \_\_\_\_\_  Unknown  Never

ADDITIONAL COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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FOR OFFICE USE ONLY:

DATE FORM(S) WERE RECEIVED IN FULL: \_\_\_\_\_