

Illness and Injury Assistance

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## Medical Leave Form (To be completed by a treating licensed health care provider)

A. PATIENT INFORMATION Please print or type in black ink							
1. Name of patient			Date of birth	Date health condition commenced?			
2. Date of initial appointment						least two appointments for treatment per year	
B. MEDICAL INFORMATION							
3. Primary diagnosis				ICD 10	GAF		
4. Secondary diagnosis					ICD 10	GAF	
5. Subjective symptoms Able to perform Able to drive				n activities of daily living Y□ N□ Self care Y□ N□ '□ N□			
6. Objective findings (diagnostic tests, laboratory or clinical findings)							
7. Treatment plan (medications, procedures, therapy, referrals)							
C. HOSPITALIZATIONS and SURGICAL PROCEDURES (if applicable)							
8. Name of hospital				Date of admission	Date of discharge		
9. Surgical procedure				Date performed/scheduled	CPT procedure code		
D. MEDICAL LEAVE and RETURNTO WORK INFORMATION							
10. Will the patient require a continuous medical leave of absence from work for this condition? Y   N   If yes:  Duration of leave needed: days   weeks   months   First date unable to work: Estimated return to work date: Will this health condition require treatment and absence from work for more than 12 continuous months? Y   N    11. Will this health condition result in episodic flares and intermittent leave from work? Y   N   If yes: Episodes per month: Days per episode: Duration of time intermittent leave will be needed: weeks   months    12. Will the patient need to attend future appointments for treatment? Y   N   If yes: Number of appointments per week   per month    Duration of appointments: hours   Estimated date treatment will be completed:  13. Will the patient need a reduced work schedule? Y   N   If yes: Hours per day able to work: Number of days able to work per week: Date able to return to a full schedule:  14. Are work restrictions needed? Y   N   If yes, check those that apply: Grasp   Reach   Lift   Kneel   Squat   Walk   Bend   Twist   Other    Please specify below any restrictions checked (e.g., No lift over 10 pounds, No reach above shoulder with right arm, Other restrictions)  Estimated date restrictions will end: Will restrictions last more than 6 months? Y   N    15. Are there cognitive impairments? Y   N   If yes, check those that apply: Memory   Concentration   Comprehension   Other    Are these impairments severe enough that work restrictions or accommodations will be needed? Y   N   If yes, please clarify below:							
E. LICENSED HEALTH CARE PROVIDER INFORMATION							
Health care provider's name (please print)	:	Signature:			Date: Email:		
Degree/specialty/credentials:		Address:			Phone: Fax:		