CHRISTIE CLINIC | THE DEPARTMENT *of* OBSTETRICS AND GYNECOLOGY

FAMILY MEDICAL LEAVE ACT / DISABILITY PATIENT QUESTIONNAIRE

We are happy to perform this service free of charge and we thank you for your patience as we have a 5-7 business day turnaround time for forms to be completed once they are received in our office. Please note that if additional information is needed from your provider, it could take longer for your form(s) to be processed.

Please answer all questions completely and return form and paperwork to the receptionist when you are done.

Date: _____ Provider: _____ Medical Record Number: _____

Name: _____ Birth date: _____ Daytime phone: _____

Obstetrical patients

Due date: _____ Do you plan to work until you deliver: Yes / No Are you off work now? Yes / No

First day off: _____ Please list any complications: _____

Were you hospitalized: Yes / No If yes, dates: _____ Hospital: _____

Delivery date: _____ Type of delivery: Vaginal or C/section Hospital: _____

Surgical patients

Date of surgery: _____ First day off work: _____ First day back to work: _____

List any complications: _____

Leave needed for a family member

Family member's name: _____ Relationship to patient: _____

Reason for leave: _____ Days off needed: _____

Once paperwork is completed

☐ Call patient when complete ☐ Patient to pick up form on: _____ (date)

Mail form to: _____

Fax form to: _____

Name of business Attention to

Fax number: _____