Indianapolis Independent Pediatricians, P.C.
Medical Forms

Please make sure all patient information is completed full prior to it being left in our office. Standard turnaround time to complete medical forms is 7-10 business days. Please plan ahead when turning paperwork into our office. Our physicians will do their best to complete forms as early as possible, however; parents should expect 7-10 business days before the paperwork will be ready. Forms are completed by our physicians and a review of the patient chart is performed with the paperwork completed outside of normal business hours.

The following information is needed. If not provided, someone from our office will have to contact you; which could hinder the forms being completed within 7-10 business days.

Today's Date:_____ Patient Name:_____ DOB:_____

$10 prepayment fee is required for medical forms.

Please complete the specific section for which form needs to be completed.

■ **FMLA**

Form is for mothers work (name):_____Form is for father's work (name):_____
Why is FMLA being requested?_____List diagnosis:_____

To care for the family member, the employee needs to miss work:

( ) Intermittently – Occasional absence due to single illness or injury

a) Check **ONE** and provide the related information:

( ) Planned, Regular Schedule

What's the requested reduced schedule (for example, 20 hours a week)?_____
How many hours can this employee work each day (for example, 5 hours)?_____
Are absences anticipated for treatment, for symptoms, or for both?_____

OR

( ) Unplanned, Unknown, or As Needed

How often will this employee be away from work (for example, twice a month)? _____
How long will this employee be away from work each time (for example, four hours)?_____
Are absences anticipated for treatment, for symptoms, or for both?_____

( ) Continuously – An uninterrupted absence for a single illness or injury

Start Date: Date employee is/was first unable to work due to the patient's serious health condition(s): _____

Anticipated Return to Work Date: _____

■**Medication to be given at School/Child Care Center**

Medication name_____ Dose_____

■**Dietary reason for School/Child Care Center**

What is the medical reason this form needs to be completed?_____
_____
What item(s) need to be restricted?_____
List food allergies: _____
Is dietary reason due to religious reasons or parent/patient preference? Please explain:_____
_____

Authorization to Release Medical Form

Patient Name:_____ DOB:_____

Please check one:

( ) I will pick up the completed medical form from Indianapolis Independent Pediatrician, P.C.
What phone number and who should we contact to let you know the form is ready?

Name: _____ Phone:_____

( ) Please fax the completed form.
I hereby authorize this medical form completed by Indianapolis Independent Pediatrician, P.C. to be faxed to:

Name:_____ Fax:_____

Phone: _____

Parent/Custodian Name (Print):_____

Parent/Custodian Name Signature:_____ Date:_____

If custodian, relationship to patient:_____

This consent will expire 60 days from the date of signature.

A photocopy or facsimile of this authorization shall be valid as the original.