UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

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MARYLAND CENTER FOR MULTIPLE SCLEROSIS

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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 being submitted 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. * (Policy effective as of March 1, 2021)*

PATIENT NAME: _____ **PATIENT DOB:** _____

PATIENT PHONE NUMBER: (____)____-_____

PATIENT ADDRESS: _____

PATIENT E-MAIL: _____

PATIENT'S PROVIDER: Please Select You 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 ACTIVITES: _____

_____

_____

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: _____

_____

_____

_____

_____

FOR OFFICE USE ONLY:

DATE FORM(S) WERE RECEIVED IN FULL: _____