



Crystal Lake Orthopedics

PATIENT REQUEST FOR FORM COMPLETION

**PLEASE ALLOW 5-7 BUSINESS DAYS FOR COMPLETION
FEE: \$10.00 FOR ALL FORMS PAYABLE AT TIME OF REQUEST**

Patient Name: _____

Date of Birth: _____ **Phone #:** _____

Name of person requesting form to be completed if different from patient:

Please indicate if this is a form for a family member of the patient and always include the length of time requested off below. Please fill out form completely. Unanswered questions will result in a processing delay.

What was your date of injury or when did your symptoms start? _____

What is your current or requested work status? OFF WORK RESTRICTED DUTY INTERMITTENT LEAVE

What was/will be the first date off work or your first date on restricted duty? _____

Estimated return to work date or estimated length of time out of work? _____

Body Part: _____ Is this a Workers Compensation case? YES NO

Do you want to have your forms: (circle one)	MAILED	FAXED	PICK UP
MAIL - Please provide address: 	FAX - Please provide number: 	PICK UP: (Circle One) Crystal Lake Huntley	

RECEPTION USE ONLY

Account Number: _____

Accepted By: _____

Date: _____

Amount Paid: _____

CLINICAL TEAM USE ONLY

Completed By: _____

Action: _____

Date: _____