

FOREST COUNTY CHILD SUPPORT AGENCY

200 E MADISON, CRANDON, WI 54520

SHANNON M. BONEY – DIRECTOR PHONE: (715)478-2157 OR FAX: (715)478-7717

(Please provide the original completed form to the Forest County Child Support Agency)

MEDICAL QUESTIONNAIRE

RE: _____

DOB: _____

TO: Primary Doctor’s name and medical facility (please print) _____

Pursuant to Wisconsin Statutes 804.10(4), the undersigned hereby consents to response by treating physician with respect to the questions set forth below. The undersigned waives patient/doctor privilege solely for purposes of responding to these questions. I understand that in responding to the questions set forth below, the health care provider may also release any records including but not limited to those relating to diagnosis, prognosis and/or treatment. The purpose of this consent is to make available to the Forest County Child Support Agency my full health care status, so that a determination can be made as to whether or not I am responsible and/or liable for child support. I also understand that this consent is revocable, except I also understand that any revocation must be in writing. Further, this consent shall remain in full force and effect for a period of one year in order to effectuate the purposes for which it is given.

Accordingly, you may release the medical information by responding to the questions that are set forth below.

Patient signature

QUESTIONNAIRE BELOW (to be filled out by a physician)

Person or agency to whom this authorization applies is: Shannon M. Boney/Forest County Child Support Director or designate Forest County Child Support Agency at: 200 E MADISON ST, CRANDON, WI 54520.

1. Please briefly describe your diagnosis of the above-named individual:

2. What is the date or approximate date of the onset of the patient's current diagnosis or disability? Please explain:

3a. Is the patient currently capable of full-time employment that is 35 hours or more per week?

YES _____

NO _____

3b. If you do not believe that the patient is currently capable of full-time employment, do you anticipate that the patient will eventually recover from his/her illness or injury so as to be capable of returning to full-time employment, and, if so, when?

YES _____

NO _____

DATE _____

4. In the event that you answered the above question "No", is it your opinion that the person's medical condition is permanent or likely to be permanent?

YES _____

NO _____

5. In the event that you answered the above question "Yes", which of the following most accurately (one or more) describes the basis for your diagnosis?

_____ X-rays

_____ CAT Scan

_____ MRI

_____ Patient's description of systems and limitations

_____ Other objective criteria. Please describe below:

6. In the event that you believe that the patient is not capable of working a full-time position, either now or in the future, is the patient able or capable of working at least part-time which for purpose of this question is 20 hours per week?

YES _____

NO _____

7. If so, the length of time in which the patient would be able to work at least part-time (at least 20 hours per week).

8. In the event that you believe that the patient is capable of working but perhaps not working at a level of employment equal to that of his/her past occupation, is the patient capable of working in any other type of employment within the patient's physical or mental capabilities including sedentary employment?

YES _____

NO _____

FULL-TIME _____

PART-TIME _____

9a. Since the date of onset of the patient's current diagnosis or disability, in your opinion, during what periods of time was the patient unable to work? Please explain:

9b. Was the inability to work pertaining to part-time or full-time employment?

10. Do you have any other comments and if so, please insert them at this time.

11. Please attach copies of any medical records that would provide additional information to substantiate the patient's claim that they are not capable of working part-time or full-time.

Physician's name (please print)

Date _____

Signature of physician/physician's practice