ALZHEIMER'S DISEASE AND RELATED DEMENTIAS

PHYSICIAN DIAGNOSIS STATEMENT

*****To be completed and signed by patient's physician***

Qualifications for the Respite Assistance Program depends on the patient's diagnosis. This respite program serves patients with Alzheimer's disease and related dementias.

PATIENT INFORMATION

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Date of Birth: ______________________________

CAREGIVER OR RESPONSIBLE FAMILY MEMBER

Name: ______________________________

Telephone: ______________________________

PHYSICIAN INFORMATION

Name: ______________________________

Signature:

Telephone: ______________________________

Date:

PLEASE CHECK ONE OF THE FOLLOWING:

☐ Alzheimer's Disease

☐ Creutzfeldt-Jakob Disease

☐ Vascular Dementia

☐ Lewy-Body Dementia

☐ Huntington's Disease

☐ Frontotemporal Dementia

☐ Parkinson's Disease

☐ Mixed Dementia