ALZHEIMER'S DISEASE AND RELATED DISORDERS

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

☐ Pick's Disease

☐ Parkinson's Disease

☐ Mixed Dementia