South Carolina
DEPARTMENT
ON AGING

Date: ___/_____/_____

Alzheimer's Disease and Related Disorders
Physician Diagnosis Statement

STATEMENT OF DIAGNOSIS

This form is to be completed & signed by patient's physician.

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

PATIENT INFORMATION (PLEASE PRINT)

Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____

CAREGIVER OR RESPONSIBLE FAMILY MEMBER (PLEASE PRINT)

Name: _____

Telephone: _____

PHYSICIAN INFORMATION

Print Name: _____ Telephone: _____

Signature: _____ Date: _____

PLEASE CHECK ONE OF THE FOLLOWING:

☐ Alzheimer's Disease ☐ Creutzfeldt-Jakob Disease ☐ Mixed Dementia ☐ Pick's Disease

☐ Huntington's Disease ☐ Lewy-Body Dementia ☐ Parkinson's Disease ☐ Vascular Dementia

Other- Please explain:

Please return this statement to:

Aeriell Bowick
Family Caregiver Advocate
Upper Savannah Council of Governments
Area Agency on Aging
430 Helix Road
Greenwood SC 29646
Direct Line: 864-941-8067
Email: abowick@uppersavannah.com