Marshfield Area Respite Care Center, Inc.
MARCC
205 E. Third Street
Marshfield, Wisconsin 54449
715-384-8478

Dear Physician,

_____has indicated an interest in participation in the Marshfield Area Respite Care Center. Your certification that he/she is diagnosed as having a dementia is necessary to determine eligibility for our program. In addition, Certification standards require further information about the general state of the prospective participant's health and general ability to participate. Please complete and sign this form and return it to the Center. The consent for release of this information is as follows:

I consent to release medical record information requested below for_____.

Signed, _____ Relationship_____
Witnessed_____ Date_____

I have examined_____ and certify that he/she is diagnosed to be suffering from an irreversible dementia resulting from any of the following disorders: (check the applicable diagnoses)

___ Alzheimer's Disease
___ Cruetzfeldt-Jacob Disease
___ Friedreich's Ataxia
___ Huntington's Disease
___ Irreversible Multi-Infarct Disease
___ Parkinson's Disease
___ Pick's Disease
___ Progressive Supranuclear Palsy
___ Wilson's Disease
___ Unspecified Irreversible Dementia
___ Does not have Irreversible Dementia

In addition, please indicate:

Is this individual free from any illness detrimental to others, including tuberculosis?
Yes___ No___. comment_____

Other current diseases, chronic conditions, drug or food allergies

_____

_____

Any restrictions in the ability of the person to participate in program activities?

_____

List medications and dosages being taken_____

_____

_____ _____

Physician's Signature Date

Please return in the enclosed envelope to the Marshfield Area Respite Care Center, 205 E. Third St., Marshfield Wisconsin 54449

Thank you for your cooperation.

Sincerely,

Marilyn Seidl-Kramer, Director