Dear Doctor:

Share the Care, Inc. is a program that is funded by and participates in the Florida Alzheimer's Disease Initiative.

Our Case Manager visits the potential client and caregiver in their home in order to fully assess him or her for program services. The primary goal is to provide "respite" for the caregiver.

Attached is a Client Medical Data Form that must be completed in its entirety and returned to this office before your patient can utilize our services. It is imperative that your statement highlights your patient's ailment of Alzheimer's Disease or any other related memory impairment. Failure to complete this form will make your client ineligible to participate in our program.

To ensure full compliance with our licensure, it is required by law that your patient is free and clear from all communicable disease (including Tuberculosis) within 45 days prior to beginning the intended services.

Yielding your time and notice for the patient in the Client Medical Data Form will be deeply appreciated by the families we serve and us. We sincerely thank you for your cooperation.

Cordially,

Mary Ellen Philbin
Chief Executive Officer

Attachment

Services that support family caregivers | Phone: 407·423·5311 • Fax: 407·849·1495
www.helpforcaregivers.org • info@helpforcaregivers.org

CLIENT MEDICAL DATA FORM
Share The Care, Inc.

THIS **ENTIRE** MEDICAL FORM MUST BE **COMPLETED** AND **SIGNED** BY A FLORIDA LICENSED HEALTH CARE PHYSICIAN.

Client Name______________________ SS#______________________

(**Indicate Alzheimer's or any memory problem**)

DIAGNOSIS____

____

********Please check one for complete statement below********
To the best of my knowledge, this client is "free" of tuberculosis and other communicable diseases. (___ Yes __ No)

Medications: List all medications with dosage and frequency currently receiving including p.r.n. medications, both prescription and non-prescriptions.

Medication	Dosage	Frequency

(If additional space is required for medications, please use reverse side)

Supervision of Self Administration by staff_________ Needs Administration___________

Physical limitations____

Rehabilitation Potential: Good ___________Fair ______________Poor_______________

May participate in non-strenuous exercise program: yes______________ no_______________

Diet: Regular____ / No added salt ____ / No concentrated sweets_____ / Milk: __Yes or No__

Allergies (Food, Drug, Other) ____

Special instructions: ____

Physician signature: ___________________________________ Date: _______________

Address: ____ Phone: __________________

Revised 8/2017