

Marshfield Area Respite Care Center, Inc.
MARCC
P.O. Box 485
Marshfield, Wisconsin 54449-0485
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,
P.O. Box 485, Marshfield Wisconsin 54449-0485

Thank you for your cooperation.

Sincerely,

Marilyn Seidl-Kramer, Director