Physician's Evaluation

(continued)

Memory Impairment / Mental Health:

Does patient suffer from a memory impairment or mental health disorder? Yes ❑ No ❑ DX: _____

If "yes" to what degree of memory impairment or mental disability does the patient present? Mild ❑ Intermediate ❑ Advanced ❑

Does patient need supervision to help keep them safe and to protect them from the ordinary hazards of their environment? Yes ❑ No ❑

Additional comments regarding patient's need for help with ADL's: _____

Physician's Signature: _____ Date: _____

(Must be signed by a Physician - M.D. or D.O.)

Physician's Name (please print): _____

Physician's Address: _____

_____ Phone: _____

(Please attach additional supportive documentation as appropriate)