



**CAREGIVER TIME OUT/ PARKINSON'S PROGRAM
PHYSICIAN'S STATEMENT**

Primary Caregiver: _____

Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician: _____

Specialty: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

In order to qualify for the Caregiver Time Out Program, a diagnosis is required. Eligibility is restricted to persons with **dementia associated with Parkinson's disease**. A recommendation for respite is required from the treating physician.

DIAGNOSIS: _____ **DATE:** _____

Do you recommend respite services for this patient? _____

Comments:

PHYSICIAN'S SIGNATURE _____ DATE _____

Return completed form to the address listed below.

Atlanta: 1925 Century Blvd. NE*Suite 10*Atlanta*GA*30345*404-728-1181*800-272-3900
Fax 404-636-9768