Kansas
Department for Aging and Disability Services

Kansas Respite for Alzheimer's & Dementia (K-RAD)

MEDICAL PROFESSIONAL STATEMENT

PART I: COMPLETED BY THE CAREGIVER

Care Recipient Name _____ DOB ____/____/____

Address _____ City _____ Zip _____

Caregiver Name_____

PART II: COMPLETED BY THE MEDICAL PROFESSIONAL

Please check one:

- ☐ In my professional opinion, the Care Recipient listed above has a **probable** diagnosis of Alzheimer's or another related dementia.
- ☐ In my professional opinion, the Care Recipient listed above has been **diagnosed** with Alzheimer's or another related dementia (please list diagnosis below).

_____

Diagnosis

X _____ **X** _____

Signature Date

Please print: _____ _____

Name Credentials

_____ _____

Address City, State, Zip