Project Lifesaver of North Augusta/Aiken County

Physician's Statement

Patient's Name: _____ Date of Birth: _____

Address: _____

City/Town: _____ County: _____ State: _____ Zip: _____

Caregiver's Name: _____ Relationship to Client: _____

Phone: (Home) _____ (cell) _____

Physician's Name: _____ Phone No.: _____

Specialty: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

In order to qualify for the Project Lifesaver program, a diagnosis is required. Eligibility is restricted to the following: **probable Alzheimer's disease or related dementia, Autism, Down Syndrome, traumatic brain injury or other conditions that may cause wandering, bolting, running and/or eloping.**

DIAGNOSIS, to include any other medical conditions: _____

_____

_____

Do you feel that the patient has to capability of wandering? _____ If so why? _____

_____

Do you recommend Project Lifesaver for this patient? _____

_____

Comment: _____

PHYSICIAN'S SIGNATURE: _____ Date: _____

Return completed form to the address listed below: Project Lifesaver of North Augusta/Aiken County

Attn: Lt. Andrew Harris
PO Box 6400
North Augusta, SC 29861

Agencies working together to save lives

Sertoma Club of North Augusta