Dear Physician:

The individual listed below receives HCBS services from the State of Kansas. They have an upcoming annual assessment with the CDDO the following information is required to complete it. I have filled out the information that I have in my records, please confirm it is correct. Feel free to make any changes necessary, sign/date and fax it back to _____. Thank you so much for your time & helping us ensure we have current information.

Name:
DOB:

Diagnosis & medications/diet/support used to treat them:

-

***Please **cross off** any diagnosis/medications that are no longer relevant. ***

Please add any new diagnoses below:

Please add any new medications below & what they are used to treat:

Special Diet: (Write in or circle one below) _____
*Pureed *Mechanical Soft *1800 Calorie *Low Sodium *Low Fat
*ADA Diet *Renal Diet *Regular Diet, no special requirements

Type of Seizures: (circle one) – Must be epileptic
*Simple Partial *Generalized-Absence (Petit Mal) *Complex Partial
*Generalized – Tonic-Clonic (Gran Mal) *Some other type of seizures

If incontinent, do they utilize briefs? (circle one) Yes / No

Physician Name: _____

_____ _____
Signature Date

Dear Physician:

The individual listed below receives HCBS services from the State of Kansas. They have an upcoming annual assessment with the CDDO the following information is required to complete it. I have filled out the information that I have in my records, please confirm it is correct. Feel free to make any changes necessary, sign/date and fax it back to 620-000-0000. Thank you so much for your time & helping us ensure we have current information.

Name: John Doe
DOB: 01-01-2001

Diagnosis & medications/diet/support used to treat them:

- Mild I/DD
- Allergic Rhinitis – Flonase, Claritin
- High Cholesterol – Simvastatin
- GERD – Omeprazole
- Urinary Incontinence – wears briefs at night
- Chronic Kidney Disease – monitored by Nephrologist & following Renal Diet
- Tardive Dyskinesia -benztropine

Please **cross off** any diagnosis/medications that are no longer relevant.

Please add any new **diagnoses** below:

Please add any new **medications** below & what they are used to treat:

Special Diet: (Write in or circle one below) Gluten Free Diet

*Pureed *Mechanical Soft *1800 Calorie *Low Sodium *Low Fat
*ADA Diet *Renal Diet *Regular Diet, no special requirements

Type of Seizures: (circle one) – Must be epileptic

*Simple Partial *Complex Partial *Generalized-Absence (Petit Mal)

*Generalized – Tonic-Clonic (Gran Mal) *Some other type of seizures

If incontinent, do they utilize briefs? (circle one) Yes / No

Physician Name: Dr. Bob Marley, Siena Medical Clinic

_____ _____
Signature Date