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:	Medication/diet/support used to treat the Diagnosis:

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

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

EXAMPLE