Project Lifesaver
Columbia County Sheriff's Office
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:_____

Specialty: _____

Address:_____

City/Town:_____ County:_____ 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 the capability of wandering?_____ If so, why?_____
_____

Do you recommend Project Lifesaver for this patient?_____
_____

Comment:_____

Physician's Signature:_____ Date:_____

Return the completed form to the address listed below:

Project Lifesaver
Columbia County Sheriff's Office
Attn: Community Services Division
2273 County Camp Rd.
Appling, GA 30808
Phone: (706) 541-2856
Fax: (706) 541-2833