

**Caldwell
House**



DATE: _____

TO: (Treatment Center) _____

RE: _____

This is to certify that _____ will be able
To function without continuous supervision and can administer his own medication
both prescribed and non-prescribed.

Department of Facility Services requires this information before admission.

Fax this form to Caldwell House at 828 757-3858

(Physician Name)

(Signature)

To Mail: Send to the Address Below

Caldwell House, Inc. – 951 Kenham Place S.W., Lenoir, NC 28645 (828) 754-5148