alzheimer's association®

Submit form at
FAX to 773.444.0934 or
E-MAIL **illinoishelpline@alz.org**
or go online to fill out form:
alzheimers-illinois.org/directconnect

Direct Connect Referral Form

Name of person being referred (patient):	**Zip Code:**
Name of person being contacted (if not the person being referred):	**Zip Code:**
Relationship to person being referred: ☐ Self ☐ Spouse/Partner ☐ Son/Daughter ☐ Grandchild ☐ Niece/Nephew ☐ Friend ☐ Other (specify)_____	
Preferred Phone:	
Primary language (if other than English):	

I give permission to my healthcare or service provider to fax or e-mail our name and contact information to the Alzheimer's Association. I understand that an Alzheimer's Association Helpline representative will contact me about support and educational opportunities. In addition to giving my permission to be contacted by the Alzheimer's Association, I give permission for the Alzheimer's Association to share a summary of our discussion with the referring provider as indicated below. I understand this is a free service provided by the Alzheimer's Association. I understand that our name, contact information or health information listed above will not be disclosed or shared with any other entity unless authorization is obtained by me.

Signature:_____ **Date:** _____

The person being referred provided verbal consent instead of their signature: ☐ **Yes**

May we identify ourselves as the Alzheimer's Association when we call? ☐ Yes ☐ No
May we leave a voicemail message? ☐ Yes ☐ No

To be completed by the healthcare professional:

Healthcare provider name:	
Healthcare provider organization and department:	
Healthcare provider email:	
Healthcare provider fax number:	**Zip Code:**
Additional comments (optional):	