alzheimer's association Direct Connect Rapid Referral

FAX TO: 314-269-1624 Date of Referral: _____

TO BE COMPLETED BY REFERRING PROVIDER

□ URGENT – Contact client immediately

Provider Name: _____ Provider Organization: _____

Phone: _____ Fax: _____ Email: _____

Reason for Referral: (Please check all that apply)

□ Diagnose: Information on dementia specialists / dementia diagnostic centers in your area

□ Educate: Disease orientation for patient & family, information about treatment, symptoms & stages

□ Support: In person, by phone or online

□ Services: 24/7 Helpline, care consultation & planning, information about resources in your area

FAMILY/FRIEND/CAREGIVER/OTHER TO BE CONTACTED

Name: _____

Relation to person with memory loss: _____

Phone: _____ Email: _____

Mailing Address: _____

City:_____ State:_____ Zip Code: _____

Preferred method of contact: □ Phone □ Email □ Mail

Preferred day/time of contact: _____

May we identify ourselves as the Alzheimer's Association when we contact you? □ Yes □ No

May we leave a voice message? □ Yes □ No

PERSON WITH MEMORY LOSS

Name: _____ Date of Birth: _____

Mailing Address: _____

City:_____ State:_____ Zip Code: _____

Diagnosis: _____ Diagnosis Date: _____

I give permission to my healthcare or service provider to fax my 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. I understand this is a free service provided by the Alzheimer's Association. I understand that my name, contact information or health information listed below will not be disclosed or shared with any other entity unless authorization is obtained by me.

Signature: _____

(Patient or Personal Representative)

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