alzheimer's association®

DIRECT CONNECT *Rapid Referral*

Submit form at

Please **FAX to 773.444.0934** or
E-MAIL **illinoishelpline@alz.org**

or go online to fill out form:
alzheimers-illinois.org/directconnect

Date: _____

Patient name: _____

Name of person being contacted (if not the patient): _____

How are you related to the person with memory loss: ❑ Self ❑ Spouse/Partner ❑ Family ❑ Friend ❑ Other

Mailing address: _____ City: _____ State: ____ Zip Code: _____

Phone: _____ Email: _____

Preferred day/time of contact by phone: (Indicate a time between Monday – Friday from 9a.m.-5 p.m.) _____

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

May we leave a voice message? ❑ Yes ❑ No

I give permission to my healthcare or service provider to fax or e-mail 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. 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 above. 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

To be completed by referring Health Care Professional

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

Diagnosis: _____

Health Care Professional's Name: _____ Provider Organization: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Phone: _____ SECURE Fax*: _____ SECURE EMAIL*: _____

**Please provide a SECURE FAX or EMAIL address in order to receive a follow up report from our helpline staff*