Indianapolis
50 E 91st, Ste 100
Indianapolis, Indiana 46240

Fort Wayne
6324 Constitution Drive
Fort Wayne, IN 46804

Merrillville
8679 Connecticut Avenue, Ste D
Merrillville, IN 46410

alzheimer's association®

Greater Indiana Chapter

Rapid Referral Form

Provider: Please FAX to (317) 582-0669

www.alz.org/indiana/clinicalproviders

Patient or Patient Representative

I give permission for my clinical provider to give my name, address, phone number, and the patient information below to the Alzheimer's Association so that a representative from the Association may contact me or my personal representative about support and educational opportunities that are available to me and my family. I understand that the Association may provide feedback to my clinical provider based on our contact.

Patient's Name_____ Date_____

Name of person to contact (if not patient) _____

Relationship to patient _____

Mailing Address _____ City_____ ZIP_____

Phone Number _____ E-mail_____

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

Signature of patient or patient representative: _____

To be completed by healthcare provider:

Diagnosis_____ Date of diagnosis_____

Caregiver was sent home with Association folder of information? ( ) YES ( ) NO
Primary Reason(s) for Referral (check all that apply):

( ) Introduction to Alzheimer's Association free programs, services, and resources
( ) Disease education and care planning
( ) Support groups
( ) Early Stage programs
( ) Home safety
( ) Legal planning (discuss medical and legal powers of attorney planning, etc)
( ) Information on community resources (adult days, transportation, respite, etc)
( ) Care Consultation
( ) Alternative living planning (Memory Care, Assisted Living)
( ) Send Patient/Caregiver packet
( ) Send Caregiver Guide
( ) Other: _____

Name of Clinical Provider (please print): _____

Phone: ***Fax:***