Alzheimer's Association, Washington State Chapter
Serving Washington State & Northern Idaho

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Medical Provider Referral Form

Referring Provider

Name: _____ Title/Role: _____

Organization:_____ Phone #: _____

Fax #: _____ Email: _____

Patient/Family Representative

I give permission for my medical provider to give my name, address, phone numbers, and patient information below to the Alzheimer's Association so that a program staff member can contact me or my family member about available services and educational opportunities. I understand that the program may be giving feedback to my medical provider based on our contact.

Your Signature: _____ Date: _____
(Patient or Family Representative)

Your Name: _____
(Please Print)

Relationship to Person with Memory Problem: ❒ Self ❒ Other _____

Phone number: (Home) _____ (Work or Cell): _____

Mailing Address: _____

To be completed by Medical Provider (or affix label):

Name of Patient: _____

Diagnosis: _____ Date of diagnosis: _____

Medical Provider: _____ Role: _____

Please indicate any specific needs of the patient or family:

❒ Information about memory loss and caregiving

❒ Patient support services/groups

❒ Family support services/groups

❒ Safety assessment-Safe Return

❒ Advanced directives

❒ Assistance with behavioral issues

❒ Long distance caregiving

Referrals for:

❒ Respite care (daycare or overnight)

❒ Home Care

❒ Assisted living/housing

❒ Legal Planning

❒ Financial counseling

❒ Other _____

Please continue to other side

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Notes (optional):

Please submit form via fax or email.
Fax: (206) 363-5700
Email: helplinewa@alz.org

Please note that referrals are typically processed within 5-7 business days.