DIRECT CONNECT REFERRAL

800-272-3900 www.alz.org/cny

alzheimer's association

Central New York Chapter

Patient/Client/Caregiver:

I understand that this form allows for a direct referral to the Alzheimer's Association, Central New York chapter so that a staff member can contact me about support, education, and/or other services.

Printed Name: _____

Signature: _____ Date:_____

Referred by:

Agency Name: _____ Contact Person: _____

Email and/or phone number: _____

Please complete this Direct Connect Referral Form, and send to the Alzheimer's Association, Central New York chapter via fax (315-472-4202) or email (cny-programs@alz.org).

Person being referred: _____

Relationship to individual with Dementia: _____

Street Address: _____

City/State/Zip Code: _____

Email: _____ Phone: (___)_____-_____

Preferred method of contact: ___Phone ___Email

May we identify ourselves as the Alzheimer's Association when we contact you? ___Yes ___No

Reason for referral:

___Care consultation and planning ___Disease information for patient and family

___Education programs ___Family consultation ___Research enrollment information (TrialMatch)

___Respite information ___Safety concerns (MedicAlert + Safe Return) ___Support Group

Additional referral comments: _____

_____

_____

_____