What Families Need to Know...
When the Diagnosis is Alzheimer’s Disease or Related Dementia

A Care and Support Workshop for Family Caregivers

Caring for someone with cognitive impairment is a 24-hour a day, 7-day a week challenge. This series of educational sessions provides an opportunity for families to learn and share together in an informal setting. Topics are presented by experts in their fields, including physicians, nurses, social workers and attorneys.

In this series, participants will:
⇒ Develop a better understanding of medical aspects of dementia, including diagnosis, stages and treatment – Part 1 - August 9 Physician presentation
⇒ Learn strategies to cope with daily challenges, such as communication, behaviors, safety and personal care – Part 2 - September 13 Clinical Staff presentation
⇒ Receive information about legal and financial planning, including advance directives, Medicaid and more – Part 3 - October 11 Attorney presentation
⇒ Identify community services to help you now and in the future, such as respite care and long-term care – Part 4 - November 8 Clinical Staff presentation

Separate Registration for each monthly meeting is required.

Hamilton County

First meeting of the four-part series on Thursday, August 9, 2018 6:30 – 8:30 p.m.
Mercy Health-West Hospital (Auditorium)
3300 Mercy Health Blvd.
Cincinnati, OH 45211

This program is free of charge. To register, complete the form below and send to: Alzheimer's Association, 644 Linn St. #1026, Cincinnati, OH 45203. FAX: 513-345-8446 To register ONLINE – Click Here

REGISTRATION: What Families Need to Know /Hamilton County – Mercy West   DATE: Thursday, August 9

How did you hear about this program?  __ Alzheimer’s Assn. staff   __ Healthcare provider   __ Family/friend/co-worker
  __ Mailing to home/work   __ TV/radio/newspaper ad   __ Website   __ Other

Name (please print):  ______________________________________________________________
Street Address: __________________________________________________________________________
City: _________________________________________ State: _________  Zip code: ________________
County: _________________________   E-mail address:  ____________________________

Telephone 1: ( ______ ) ______________________  Telephone 2: ( ______ ) _______________________
  Circle one: Home   Work   Cellular
  Circle one: Home   Work   Cellular
Your Gender:  __ M  __ F   Your Age: _____   Your highest level of Education: ______________________
Your Ethnicity:  __ White   __ Black   __ Hispanic   __ Native Amer.   __ Asian   __ Other: ______________________
Your relationship to person with illness:  __ Self  __ Spouse  __ Adult child/in-law  __ Sibling  __ Other: _______
Age of person with illness:  _______   Gender of person with illness:  __ Male   __ Female   Veteran:  __ Yes  __ No
Diagnosis:  ____________________________________________________________ Date of diagnosis (estimated): ____________