Referral Form

Date: _______________

Referred by: ________________________ Agency: ____________________________

Phone: ____________________________ Email: _____________________________

Fax: _______________________________

*You will receive information back from us on this client. Do you prefer to receive it via:

- ◊ Fax
- ◊ Email

Name of Patient/Client: ____

Name of Person to be contacted by the Alzheimer's Association:

____

Relationship to Person with Memory Loss: ___self ___spouse ___child ___sibling ___other

Address:

____

____

Home Phone: _______________Work Phone: _______________Cell Phone: _______________

Email: ___________________________________

FREE Programs & Services

Helpline: 24/7 telephone information & referral service
Early-Stage Services: Education & support programming for individuals with memory loss and their family
Care Consultation: Personalized assistance for caregivers/family members to address safety concerns, caregiver stress, decision making, communication, and behavior challenges
Education Programs: Community-based programs for individuals with memory loss and caregivers
Support Groups: Community-based groups for caregivers

Please send to: Mary Ertle Fax: 216-373-0886
Email: cleveland-helpline@alz.org
Phone: 216.342.5583