



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: Rebecca Zeiter, LSW

Fax: 216-373-0886

Email: cleveland-helpline@alz.org

Phone: 216.342.5583