alzheimer's association
Central and Western Virginia Chapter
355 Rio Rd. West, Ste. 102 Charlottesville, VA 22901 Phone 434.973.6122 / 800.272.3900

MEMORY LOSS FAX REFERRAL FORM

FAX to: 434.973.4224

Patient/Caregiver:
I give permission for the physician named below to give my name, address, phone number, and the patient information below to the Alzheimer's Association so that a staff person may contact me or my personal representative about support, education, and/or service referral opportunities that are available to me and my family. I understand there is no cost to me, the patient; that this is a free service provided by the Alzheimer's Association. *If follow-up is requested by my physician as indicated below*, I give permission for the Alzheimer's Association to provide a summary of the contact.
I understand the health information listed below may not be further used or disclosed unless another authorization is obtained by me or unless such use or disclosure is required or permitted by law.

Signature: _____Date: _____
(*Patient or his/her Personal Representative*)

Your Name (*Please Print*): _____Phone:_____

Address:_____

City/State/ZipCode:_____
Email:_____

Relationship to Person with Memory Loss: Self: ___ Other: _____

To Be Completed by Healthcare Professional (*FAX to 434.973.4224****)***

Patient Name:_____ Date of Birth_____

Diagnosis: _____Date of Diagnosis:_____

Healthcare Professional (*Please Print*):_____
Preferred Method of Contact (*Please Circle One*): Phone_____
Fax_____or Email _____

Reason for Referral: (*Please Circle All that Apply*)

Orientation/Education	Support Groups
Care Consultation	Respite Providers
Care Partner Education	Early Memory Loss Programs
Community Resources	Other_____
Safety Concerns	

Please provide follow-up information to Referring Physician_____