RAPID REFERRAL FORM

ALZHEIMER'S ASSOCIATION®

EMAIL OR SCAN TO: rapidreferral232@alz.org

Date: _____

Please check *one* of the following:

☐ I am a person diagnosed with dementia ☐ I am a caregiver for a person with dementia

Name of Person with Dementia (PWD): _____

Name of Caregiver: _____ Relationship to PWD: _____

Phone: _____ Email: _____

Mailing Address: _____

May we identify ourselves as the Alzheimer's Association when we contact the client? ☐ Yes ☐ No

Do we have permission to leave a message if needed? ☐ Yes ☐ No

Preferred Method of Contact: ☐ Phone ☐ Email ☐ Postal Mail

24/7 Helpline: 1.800.272.3900

The Alzheimer's Association's 24/7 Helpline is available 24 hours a day, 7 days a week, 365 days a year. It is a free service for anyone looking for more information or support. Speak confidentially with master's-level care consultants for decision-making support, crisis assistance and education on issues families face every day. Helpline support is available is more than 200 languages.

I give permission to my healthcare or service provider to share my name and contact information with the Alzheimer's Association so a representative may contact me about local resources and support services. I understand that my name, contact information and/or health information listed below will not be disclosed or shared with any other entity unless authorization is obtained by me.

Signature: _____ **OR** Verbal Permission Given: ☐ Yes
(Patient or Personal Representative)

TO BE COMPLETED BY REFERRING PROVIDER

Diagnosis: _____ Diagnosis Date: _____

Provider Name: _____ Organization: _____

Phone: _____ Fax: _____

Email: _____

Written summary of patient contact requested: ☐ Yes ☐ No

Reason for Referral: *(Please check all that apply)*

☐ Basic disease education
☐ Education programs
☐ General information and referral
☐ Support groups
☐ Early stage programs
☐ Other: _____

For care consultations, planning, coaching and safety issues, please give the patient the number for the Helpline: 1.800.272.3900.