alzheimer's association®

Provider: Please FAX to 317.582.0669 | Date of Referral:_____ | www.alz.org/indiana/clinicalproviders

**required fields*

Office Use Only (Please Print):

Provider Name: _____ Provider Organization:_____

Phone: _____ Fax: _____ Email: _____

Reason for referral (Please check all that apply):

- ☐ Diagnose: Information on dementia specialists/ dementia diagnostic centers in your area
- ☐ Educate: Disease orientation for patient & family, information about treatment, symptoms & stages
- ☐ Support: In person, by phone or online
- ☐ Services: 24/7 helpline, care consultation & planning, information about resources in your area

Family/ Friend/Caregiver/Other to be contacted:

Name: _____

Relation to person with memory loss: _____

Phone: _____ Email: _____

Mailing Address: _____

City: _____ State:_____ *Zip Code:_____

Preferred Method of Contact: ☐Phone ☐Email ☐Mail Preferred Language:_____

Preferred Day/Time of contact: _____

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

May we leave a voice message? ☐ Yes ☐ No

Person with Memory Loss:

Name: _____ DOB:_____

Mailing Address: _____

City: _____ State:_____ Zip Code:_____

Diagnosis:_____ Diagnosis Date:_____

I give permission to my healthcare or service provider to fax my name and contact information to the Alzheimer's Association. I understand that the Alzheimer's Association representative will contact me about support and educational opportunities. I understand this is a FREE service provided by the Alzheimer's Association. I understand that my name, contact information or health information listed above will not be disclosed or shared with any other entity unless authorization is obtained by me.

Signature:_____ Date:_____

(Patient or Personal Representative)

The person being referred provided verbal consent instead of their signature: ☐ Yes