alzheimer's association®

RAPID PATIENT/FAMILY REFERRAL

Please complete form to the best of your ability.

Date:_____

Referring healthcare provider: _____

Provider organization: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Email:** _____

CAREGIVER INFORMATION

Name: _____

Mailing Address:

_____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____**Email:** _____

How are you related to the person with memory loss?

☐ **Spouse/Partner** ☐ **Family** ☐ **Friend** ☐ **Other**

PATIENT INFORMATION

Name: _____

Mailing Address (if different from caregiver's information): _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____**Email:** _____

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

May we leave a voice message? ☐ **Yes** ☐ **No**

I give permission to my healthcare provider to provide my name and contact information to the Alzheimer's Association. I understand that an 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.

Patient or Caregiver signature:_____

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

Please fax this form to the Alzheimer's Association Long Island Chapter at 631.514.3028

Call our 24/7 Helpline anytime at 800.272.3900