Rapid Referral

Partnering with healthcare providers to improve care and support Alzheimer’s patients and families

Healthcare providers offer **optimal support**, improve **coordinated care**, complement **patient service delivery** and ensure the **psycho-social needs** of those living with Alzheimer’s and related dementias and their family members through **direct referral** to the Alzheimer’s Association Greater Maryland Chapter.

Rapid Referral provides, **free of cost**, for those living with Alzheimer’s and their families:

- **Education** including dementia symptoms, stages of the disease and other information
- Connections to numerous community **resources**
- Access to **trained clinicians** who can help families navigate through the disease
- **Support groups** and **social engagement programs** that provide meaningful interactions
- The ability to remain at home as long as possible through **safety services**
- **Support** so that families can more effectively plan ahead, cope and manage

Rapid Referral does not fulfill mandatory legal reporting requirements of healthcare professionals. The Alzheimer’s Association Greater Maryland Chapter maintains high professional and ethical standards for care and safety and reports elder and child abuse.

For additional questions, contact:

Alzheimer’s Association Greater Maryland Chapter
Marlyn Taylor, mataylor@alz.org
1850 York Road, Suite D
Timonium, MD 21093
410.561.9099 ext.1842

See reverse for Rapid Referral

alzheimer's association®  | alz.org/maryland | 800.272.3900

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Rapid Referral Form

Fax number: 410.561.3433 | Email: info.maryland@alz.org | Date: __________________________

Person with dementia name: ___________________________________________ DOB: __________

Address: ______________________________ City: __________________ Zip: __________

Phone: ______________________________ Email: __________________________

Family member or Personal representative name: __________________________ Relationship: __________________________

Address: ______________________________ City: __________________ Zip: __________

Phone: ______________________________ Email: __________________________

Please contact □ Person with dementia, or □ Family member/personal representative

Primary Language: □ English □ Spanish Other (specify) __________________________

Additional instructions for the Alzheimer’s Association in case staff are unable to contact you:

□ The Alzheimer’s Association may leave their organization name and contact name on my voicemail
□ Do not leave a voicemail
□ The Alzheimer’s Association may contact me via email or postal mail
□ Other instructions __________________________

I give permission to the healthcare provider below to forward the information on this sheet to the Alzheimer’s Association Greater Maryland Chapter and I understand that a representative from the Alzheimer’s Association will contact me.

Signature: __________________________ Date: __________________________

(person with dementia or personal representative)

TO BE COMPLETED BY REFERRING PROVIDER

Diagnosis: __________________________ Diagnosis date (if available): __________

Name of provider: __________________________ Title: __________________________

Provider organization: __________________________ Phone: __________________________

Fax: __________________________ Email: __________________________

How would you like to receive follow up? □ Fax □ Email

Reason for referral (check all that apply): □ Caregiver education □ Psycho-social consultation
□ Clinical trial enrollment □ Safety issues and wandering
□ Healthcare directives □ Support groups (early stage/caregiver)
□ Information and referrals □ Other (specify) __________________________

□ Legal and financial considerations

Additional relevant information: __________________________________________

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