

alzheimer's association® **Direct Connect Referral**

FAX/EMAIL: Western Carolina Chapter

FAX #: 1-877-319-9652 EMAIL: directconnect@alz.org

Date: _____

Patient's Name: _____

Contact's Name: _____

Relationship to Patient: Self Family/friend Other _____

Phone: _____ Email: _____

Mailing Address: _____

City: _____ Zip Code: _____

Language Preference: _____

Preferred day/time of contact: Monday Tuesday Wednesday Thursday Friday

Morning Afternoon

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

I give permission to my healthcare or service provider to fax my name and contact information to the Alzheimer's Association. I understand that an Alzheimer's Association Helpline Specialist 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 below will not be disclosed or shared with any other entity unless authorization is obtained by me.

Signature: _____ or Verbal Permission Given:

If a situation is urgent in nature, please call our 24/7 Helpline directly at 1.800.272.3900.

TO BE COMPLETED BY REFERRING PROVIDER

(Patients and/or families will be contacted by the Alzheimer's Association within 7-10 business days of receipt of referral)

Diagnosis: _____

Provider Name: _____

Name of Practice/Clinic: _____

Phone: _____ Fax: _____

Signature of Referring Provider: _____ Date: _____

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
- Minds In Motion:** Support, social engagement, and education programs for individuals in the Early Stage and their care partners