

alzheimer's association®

Patient & Family

Patient Referral Form

Family only

Patient Only

**Provider: Please FAX to (717) 651-5066 or scan and email to referpa@alz.org
24/7 Helpline: 1-800-272-3900**

Patient

I give permission for my physician to give my name, address, phone number, and the patient information below to the Alzheimer's Association so that a representative from the Association may contact me or my personal representative about support and educational opportunities that are available to me and my family. I understand that the Association will be providing feedback to my physician based on our contact.

Patient's Name _____
(Please Print)

Patient's Signature _____ Date _____

Mailing Address _____

Phone Number _____

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

* * * * *

Personal Representative's Name _____ Date _____
(Please Print)

Personal Representative's Signature _____

Mailing Address _____

Phone Number _____ Relationship to Patient: _____

To be completed by Physician:

Diagnosis _____ **Date of diagnosis** _____ **MoCA/MMSE Score** _____

Primary Concerns/Reason for Referral:

- | | | |
|--|--|---|
| <input type="radio"/> Respite- Adult Day Programs | <input type="radio"/> Caregiver Stress | <input type="radio"/> Wandering Concerns |
| <input type="radio"/> Respite- In-Home Caregivers | <input type="radio"/> Behavioral Issues | <input type="radio"/> Driving Concerns |
| <input type="radio"/> Peer to Peer Outreach Program | <input type="radio"/> Difficulty Coping | <input type="radio"/> Support Groups |
| <input type="radio"/> Initial Care Consultation | <input type="radio"/> Multiple Family Issues | <input type="radio"/> Medic Alert & Safe Return |
| <input type="radio"/> Diagnosed Individual Lives Alone | <input type="radio"/> Early stage social engagement programs | <input type="radio"/> Safety Issues |
| <input type="radio"/> Placement Support | <input type="radio"/> Legal/Financial | <input type="radio"/> Education |

Physician's Name (please print): _____

Phone:

Fax:

Name of Patient's Primary Care Neurologist: (if other than self)

The Alzheimer's Association Constituent Services Team will provide support, information, and one-on-one consultation.

Every effort will be taken to contact the individual/family.

**Alzheimer's Association
Greater Pennsylvania Chapter**