ALZ DIRECT CONNECT

REFERRAL PROGRAM

...partnering with Healthcare Providers to *improve care and support* for patients with Alzheimer’s or Dementias & their families

**ALZ DIRECT CONNECT** allows healthcare providers to directly link patients and families to the Alzheimer’s Association, California Southland Chapter for:

- access to *care coordination* and *psychosocial support*
- referrals to *supportive services* (often at no cost)
- help with *understanding the disease* & *navigating its progression*
- a 360 approach to care through *feedback to the referring provider*

**HELPS**
families understand Alzheimer’s & other dementias

**CONNECTS**
families to resources & education

**IMPROVES**
coordinated care & builds supportive networks

**ADDITIONAL QUESTIONS?**
Contact (323) 930-6272

**ALZ DIRECT CONNECT** does not fulfill mandatory legal reporting requirements for healthcare professionals. The Alzheimer’s Association, California Southland Chapter maintains high professional & ethical standards for care & safety and therefore reports any and all allegations or suspicions of elder abuse and/or child abuse.
ALZ DIRECT CONNECT REFERRAL FORM

Fax or email this form to the Alzheimer’s Association, California Southland Chapter

Fax # 323.686.5106 Email alzdirectconnect@alzla.org Date ___________

PATIENT Name ___________________________________________ DOB ___________

Address ___________________________ City ___________________________ Zip ___________

Phone # ___________________________ Email ___________________________

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

Is the patient on Medi-Cal and Medicare? □ Yes □ No

FAMILY CAREGIVER Name (if available) ___________________________

Address ___________________________ City ___________________________ Zip ___________

Phone # ___________________________ Email ___________________________

Relationship to Patient: □ Spouse/Partner □ Child □ Parent □ Other (specify) ___________________________

I give permission to the referring provider to forward my contact and patient information to the Alzheimer’s Association, California Southland Chapter. I understand that a Chapter representative will contact me and/or my caregiver about support, programs, and other services and will follow up with the referring provider. Referrals may be entered into the national Alzheimer’s Association database, unless indicated otherwise by checking this box □.

Signature ___________________________ Date ___________

(Patient or Personal Representative)

The person being referred provided verbal consent instead of signature □ Yes

REASON FOR REFERRAL (check all that apply)

□ Care Manager Support □ Research & Clinical Trials Information
□ Support Groups □ Legal and Financial Considerations
□ Activity Programs □ Healthcare Directives
□ Safety Issues □ Respite Services
□ Home Safety □ Long-term Care Referrals
□ Conversations about Driving □ Caregiver Education
□ Wandering (MedicAlert® + Safe Return®) □ Other (specify) ___________________________

Additional Information

______________________________________________________________

______________________________________________________________

______________________________________________________________

Referring Provider Name ___________________________ Title ___________________________

Health Plan/Provider Organization ___________________________

Phone # ___________________________ Fax # ___________________________ Email ___________________________

How would you prefer to receive follow-up? □ Fax □ Email