alzheimer's association®

California Southland Chapter

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**

ADDITIONAL QUESTIONS?
Contact (323) 930-6272

See reverse for ALZ Direct Connect Referral

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

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REASON FOR REFERRAL *(check all that apply)*

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