ALZ DIRECT CONNECT

Partnering with Healthcare Providers to Improve Care...
Supporting Alzheimer's Patients & Families

HEALTHCARE PROVIDERS in clinical settings… provide **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… are addressed through **DIRECT REFERRAL** to the **ALZHEIMER'S ASSOCIATION, CALIFORNIA SOUTHLAND CHAPTER**.

ALZ DIRECT CONNECT provides **free of cost** for those living with Alzheimer's & their families:

- **EDUCATION** including dementia symptoms, stages of the disease, & other information
- connections to numerous community **RESOURCES**
- access to trained clinicians who can help families **NAVIGATE** through the disease
- **SUPPORT GROUPS** and **ACTIVITY 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, & manage

ADDITIONAL QUESTIONS?

Contact (323) 930-6272

See reverse for ALZ DIRECT CONNECT Referral Form

ALZ DIRECT CONNECT does not fulfill mandatory legal reporting requirements of healthcare professionals. The Alzheimer's Association, California Southland Chapter maintains high professional and ethical standards for care and safety and reports elder and child abuse.

alzheimer's association® | California Southland Chapter

ALZ DIRECT CONNECT REFERRAL FORM

FAX #: (323) 686-5106 **Date**: _____

Email: alzdirectconnect@alzla.org (Alzheimer's Association, California Southland Chapter)

TO BE COMPLETED BY PATIENT/PERSONAL REPRESENTATIVE

PATIENT Name: _____ **DOB:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Primary Language: ☐ English ☐ Spanish ☐ Other (specify) _____

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 below to forward my name, contact information, and patient information to the Alzheimer's Association. I understand that an Alzheimer's Association representative will contact me and/or my caregiver about support, programs, and other opportunities, will acknowledge receipt of this referral, and will provide follow up the referring provider.

Signature: _____ **Date:** _____

(Patient or Personal Representative)

The person being referred provided verbal consent instead of signature: ☐ Yes

TO BE COMPLETED BY REFERRING PROVIDER

Diagnosis: _____ **Diagnosis Date: (if available)** _____

Patient Insurance: ☐ Medicare ☐ MediCal *(check both if patient is dual eligible)* ☐ Other _____

Patient's Health Plan/Provider Organization: _____

Name of Referring Provider: _____ **Title:** _____

Phone: _____ **Fax:** _____ **Email:** _____

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

Reason for Referral: *(Please check all that apply)*

- ☐ Support Groups (Early Stage and/or Caregiver)
- ☐ Psycho-Social Consultation
- ☐ Activity Programs
- ☐ Safety Issues
  - ☐ Home Safety
  - ☐ Conversations about Driving
  - ☐ Wandering (MedicAlert® + Safe Return®)
- ☐ Clinical Trial Enrollment (TrialMatch®)
- ☐ Legal and Financial Considerations
- ☐ Healthcare Directives
- ☐ Respite Services
- ☐ Information and Referrals
- ☐ Caregiver Education
- ☐ Other (specify) _____

Additional Relevant Information:

_____