Alzheimer's LOS ANGELES

ALZ DIRECT CONNECT

REFERRAL PROGRAM

Partnering with healthcare and aging service providers to improve care and support for people with Alzheimer's or dementias & their families

ALZ DIRECT CONNECT allows healthcare and aging services providers to directly link patients/clients and families to Alzheimer's Los Angeles for:

- access to care coordination & psychosocial support
- referrals to supportive services
- help with understanding the disease & navigating its progression
- a 360 approach to care through feedback to the referring provider

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ALZ DIRECT CONNECT does not fulfill mandatory legal reporting requirements for healthcare professionals. Alzheimer's Los Angeles 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

Alzheimer's LOS ANGELES

Fax or email this form to **Alzheimer's Los Angeles**

Fax #: 323.686.5106 Email: alzdirectconnect@alzla.org Date_____

PATIENT/CLIENT NAME

_____

Address_____

City_____ Zip_____

Phone#_____

Email _____

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

_____

The patient/client is on:

☐ Medi-Cal only ☐ Medicare only

☐ Medi-Cal **AND** Medicare

FAMILY CAREGIVER NAME (if available)

_____

Address_____

City_____ Zip_____

Phone#_____

Email _____

Relationship to Patient/Client:

☐ Spouse/Partner ☐ Child

☐ Other (specify)_____

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

_____

I give permission to the referring provider to forward my contact and patient information to Alzheimer's Los Angeles. I understand that a representative will contact me and/or my caregiver about support, programs, and other services and will follow up with the referring provider. Services are provided virtually and/or in-person.

Referrals will be entered into our secure database, unless indicated otherwise by checking this box. ☐

Signature _____ Date_____

(Patient/Client or Personal Representative/Family Caregiver)

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

REASON FOR REFERRAL (check all that apply)

☐ Dementia Consultation, One-to-One Education & Support

☐ Early Memory Loss/Mild Cognitive Impairment Services

☐ Support Groups

☐ Activity Programs

☐ Safety Issues (home safety, driving, wandering, etc.)

☐ Research & Clinical Trials Information

☐ Advance Care Planning/Legal Considerations

☐ Respite Services

☐ Caregiver Classes/Workshops

☐ Other (specify)_____

Additional Information:_____

_____

REQUIRED INFORMATION

Referring Provider Name _____ Title _____

Provider Organization _____

Phone #_____ Email _____