Alzheimer's | GREATER 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 Greater Los Angeles** 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) 930-6277

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

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

Fax # 323.686.5106 **Email** alzdirectconnect@alzla.org **Date** ______________

☐ Check if primary contact

PATIENT/CLIENT NAME

____

Address_______________________________________

City_____________________________**Zip** __________

Phone#_______________________________________

Email ____

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

____

Is the patient/client on Medi-Cal AND Medicare?

☐ Yes ☐ No

☐ Check if primary contact

FAMILY CAREGIVER NAME (if available)

____

Address_______________________________________

City_____________________________ **Zip** _________

Phone#_______________________________________

Email ____

Relationship to Patient/Client: ☐ Spouse/Partner

☐ Child ☐ Professional Caregiver ☐ 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 Greater 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. **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)*

- ☐ Social Work Consultation & Support
- ☐ Support for Newly Diagnosed
- ☐ Support Groups
- ☐ Activity Programs
- ☐ Safety Issues
  - ☐ Home Safety
  - ☐ Driving
  - ☐ Wandering (MedicAlert®)
- ☐ Research & Clinical Trials Information
- ☐ Legal & Financial Considerations
- ☐ Healthcare Directives
- ☐ Respite Services
- ☐ Caregiver Education
- ☐ Other (specify)______________________________

Additional Information

____

____

REQUIRED INFORMATION

Referring Provider Name ______________________________________ **Title** ________________________________

Provider Organization ____

☐ Healthcare organization
☐ Non-medical community organization

Phone # _____________________ **Fax #**______________________ **Email**_______________________________

How would you prefer to receive follow-up? ☐ Fax ☐ Email ☐ Follow-up unnecessary

Alzheimer's | GREATER LOS ANGELES