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**

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

**CONNECTS** families to resources & education

**IMPROVES** coordinated care & builds supportive networks

**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 ________________________________________
Primary Language: □ English □ Spanish □ Other (specify)

_______________________________________________

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

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