



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



844.HELP.ALZ • [AlzheimersLA.org](https://www.alzheimersLA.org)

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



Fax or email this form to Alzheimer's 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 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

Early Stage Services

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 _____

Phone # _____ Fax # _____ Email _____

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