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

HELPS families understand Alzheimer's & other dementias

CONNECTS families to resources & education

IMPROVES coordinated care & builds supportive networks

844.HELP.ALZ • 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.

See reverse side for ALZ Direct Connect® Referral Form

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** _____

☐ 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