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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Alzheimer's Los Angeles does not bill families for services, but health plan information is collected for tracking purposes and to facilitate access to services.

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 _____

Date of Birth _____

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

_____

The patient/client is on:

☐ Medi-Cal
Medi-Cal Plan Name_____
Medi-Cal ID # _____

☐ Medicare
Medicare Plan Name_____
Medicare ID # _____

FAMILY CAREGIVER NAME (if available)

_____

Address_____

City_____ Zip_____

Phone#_____

Email _____

Relationship to Patient/Client:

☐ Spouse/Partner ☐ Child

☐ Other (specify)_____

Date of Birth_____

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_____