



# 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://AlzheimersLA.org)**

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



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

Fax #: 323.686.5106    Email: [alzdirectconnect@alzla.org](mailto:alzdirectconnect@alzla.org)    Date \_\_\_\_\_

## Name of Person Experiencing Cognitive Impairment

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Phone# \_\_\_\_\_

Email \_\_\_\_\_

Date of Birth \_\_\_\_\_

Primary Language:

English    Spanish    Mandarin

Other (specify) \_\_\_\_\_

The patient/client is on:

Medi-Cal, Plan Name \_\_\_\_\_

ID # \_\_\_\_\_

Medicare, Plan Name \_\_\_\_\_

ID # \_\_\_\_\_

## Name of Caregiver

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Phone# \_\_\_\_\_

Email \_\_\_\_\_

Relationship to Patient/Client:

Spouse/Partner    Child

Other (specify) \_\_\_\_\_

Date of Birth \_\_\_\_\_

Primary Language:

English    Spanish    Mandarin

Other (specify) \_\_\_\_\_

Preferred Method of Contact:

Email    Phone    Text

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, 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

Caregiver Classes/Workshops

Ongoing Dementia Care Management

Other (specify) \_\_\_\_\_

Additional Information: \_\_\_\_\_

## REQUIRED INFORMATION

**Please ensure that someone from your team has discussed this referral with the family, and that they are expecting contact from Alzheimer's Los Angeles.**

Referring Provider Name \_\_\_\_\_ Title \_\_\_\_\_

Provider Organization \_\_\_\_\_

Phone # \_\_\_\_\_ Email \_\_\_\_\_

Alzheimer's Los Angeles will provide feedback to the referring partner, unless indicated otherwise by checking this box.