** PROVIDER REFERRAL FORM**

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| --- |
| **Fax to: 844.699.3670** |

# **Caregiver/Patient** being referred:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Caregiver Name: | | | | | | Date: | | | | | | | | | | | | | |
| Person with Dementia’s Name: | | | | | | | | | | |  | | | | | | | | |
| Relationship to Patient: | | | | | | | | |  | | | | | | | | | | |
| Diagnosis: | | | |  | | | | | | | | | | | | Date of Diagnosis: | | | \_\_ |
| Address: | | |  | | | | | | | | | | | | | | | | |
| Telephone: | | | |  | | | | | | | | | Email: | |  | | | | |
| Primary Language: | | | | | | | | English Spanish Other: | | | | | |  | | | | | |
| Preferred Method, Day and Time of Contact: | | | | | | | | | | | |  | | | | | | | |
| May we identify ourselves as the Alzheimer’s Association when we contact you? Yes No | | | | | | | | | | | | | | | | | | | |
| I give permission to my healthcare provider to Fax my name and contact information to the Alzheimer’s Association. I understand that an Alzheimer’s Association representative will contact me about support and educational opportunities. I understand this is a free service provided by the Alzheimer’s Association. I understand that my name, contact information or health information listed below will not be disclosed or shared with any other entity unless authorization is obtained by me. | | | | | | | | | | | | | | | | | | | |
| **Signature:** | | |  | | | | | | | | | | | | | | | | |
|  | | | (Patient or Personal Representative) | | | | | | | | | | | | | | | | |
| Provider name (or stamp): | | | | | | | | | |  | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | | | | | | |
| Office Phone: | | | | |  | | | | | | | | | | | | | | |
| Provider’s Name |  | | | | | | | | | | | | | | | | | | |
| Contact (Provider’s Office): | | | | | | |  | | | | | | | | | | Date: |  | |

The Alzheimer’s Association Nebraska Chapter will provide the family with support, information, and care consultation. Every effort will be taken to contact the individual/family.

**ALZHEIMER’S ASSOCIATION NEBRASKA CHAPTER**