** PROVIDER REFERRAL FORM**

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| **Fax to: 844.699.3670** |

# **Caregiver/Patient** being referred:

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| 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**