



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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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

Date _____

PATIENT/CLIENT NAME

Address _____

City _____ Zip _____

Phone# _____

Email _____

Primary Language: English Spanish Other (specify) _____

The patient/client is on:

Medi-Cal only Medicare only

Medi-Cal **AND** Medicare

FAMILY CAREGIVER NAME (if available)

Address _____

City _____ Zip _____

Phone# _____

Email _____

Relationship to Patient/Client:

Spouse/Partner Child

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. 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 _____