Referral Form

Please fax or email information back to your local Alzheimer's Association Chapter

Person Making Referral: ________________________________ **Date:** ________________________

Area Agency on Aging: _________________________ **Phone:** ______________ **Fax:** ______________

Email for Referrer: ____

Permission to Release Contact Information

Permission for release of name and contact information intended as a referral for education, support and resources as it relates to memory loss, Alzheimer's disease and other forms of dementia.

"I give my permission to release my name and contact information to the Alzheimer's Association. The Association has my permission to contact me. I understand that the purpose of this contact is to provide free education, support, care planning and community resources as it relates to memory loss, Alzheimer's disease and other forms of dementia".

Name of person to be contacted (Print): ____

Signature of person to be contacted: ____

Type of consent provided: ☐Verbal ☐Written

Contact Information

Person to be contacted by Alzheimer's Association Role (check one): ☐ **Client** ☐ **Caregiver**

If caregiver, relationship to client (Check One):
☐**Spouse** ☐**Child** ☐**Sibling** ☐**Other** (Please Explain): ___________________________

Address: ____

City: ___________________ **State:**_________ **Zip Code:** ___________________

Primary Phone Number: ________________ **Check One:** ☐ Home ☐ Work ☐ Mobile
Secondary Phone Number: __________________ **Check One:** ☐ Home ☐ Work ☐ Mobile
Preferred Method of Contact: ____________ **Is it okay to leave a voice message?** ☐Yes ☐ No

Email Address: _______________________________

Additional Information:

Follow-up is requested by referring agency: ☐Yes ☐No **If yes, how:** ☐ Fax ☐ Email