

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 Greater Los Angeles** for:

- access to **care coordination** and **psychosocial support**
- referrals to **supportive services** (often at no cost)
- help with **understanding the disease & navigating its progression**
- a 360 approach to care through **feedback to the referring provider**



ADDITIONAL QUESTIONS?

Contact (323) 930-6277

ALZ DIRECT CONNECT does not fulfill mandatory legal reporting requirements for healthcare professionals. Alzheimer's Greater 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 Greater Los Angeles

Fax # 323.686.5106

Email alzdirectconnect@alzla.org

Date _____

Check if primary contact

PATIENT/CLIENT NAME

Address _____

City _____ Zip _____

Phone# _____

Email _____

Primary Language: English Spanish Other (specify)

Is the patient/client on Medi-Cal AND Medicare?

Yes No

Check if primary contact

FAMILY CAREGIVER NAME (if available)

Address _____

City _____ Zip _____

Phone# _____

Email _____

Relationship to Patient/Client: Spouse/Partner

Child Professional Caregiver 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 Greater 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. **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)

- | | |
|---|---|
| <input type="checkbox"/> Social Work Consultation & Support | <input type="checkbox"/> Research & Clinical Trials Information |
| <input type="checkbox"/> Support for Newly Diagnosed | <input type="checkbox"/> Legal & Financial Considerations |
| <input type="checkbox"/> Support Groups | <input type="checkbox"/> Healthcare Directives |
| <input type="checkbox"/> Activity Programs | <input type="checkbox"/> Respite Services |
| <input type="checkbox"/> Safety Issues | <input type="checkbox"/> Caregiver Education |
| <input type="checkbox"/> Home Safety | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Driving | |
| <input type="checkbox"/> Wandering (MedicAlert®) | |

Additional Information

REQUIRED INFORMATION

Referring Provider Name _____ Title _____

Provider Organization _____ Healthcare organization
 Non-medical community organization

Phone # _____ Fax # _____ Email _____

How would you prefer to receive follow-up? Fax Email Follow-up unnecessary