Referral for Information and Assistance

Patient name: ____ **Date of birth:** ______________________

I, ____ give permission for __________________________
____ to release this completed form to:

☐ Alzheimer's Association: (414) 479-8800, fax number (414) 479-8819
☐ Alzheimer's and Dementia Alliance of Wisconsin: (888) 308-6251, fax number (608) 232-3407
☐ Aging and Disabilities Resource Center: ____
☐ Other: ____

The purpose of the referral is to obtain information on (only check the primary reason):
☐ Mild cognitive impairment or a dementia diagnosis
☐ Terminology and definitions of commonly used services and support assistance
☐ Brain health and aging well strategies
☐ Minimizing caregiver stress
☐ Education programs, support assistance, and social activities
☐ The areas of home safety, in-home services, adult day programming, and other community services
☐ Alternative housing living options
☐ Clinical trials research opportunities
☐ Possible financial support assistance and programs / benefit specialists services
☐ Other: ____
____
____

Contact should be made with:
☐ Patient
☐ Support person (s): ___________________________________ Relationship to patient: ______________

Preferred method of contact:
☐ Phone: ____________________ ☐ Email: ______________________ ☐ Other: _____________________

Preferred day/time to contact: ____

Signature: ____ **Date:** ________________________

Print your name: ____ if this form is being completed by a person with legal authority to act an individual's behalf, such as a legal guardian or a health care agent. The reason of legal authority: ____.

(Note: the healthcare system's medical records and legal departments would need to add required HIPAA and legal language in the document.)