Wisconsin Alzheimer's Institute
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

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: _____
_____
_____

Referring person: _____ Referring organization: _____
Phone: _____ Email: _____

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.)