



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



844.HELP.ALZ • AlzheimersLA.org

Alzheimer's Los Angeles does not bill families for services, but health plan information is collected for tracking purposes and to facilitate access to services.

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 _____

Date of Birth _____

Primary Language: English Spanish Other (specify) _____

The patient/client is on:

Medi-Cal

Medi-Cal Plan Name _____

Medi-Cal ID # _____

Medicare

Medicare Plan Name _____

Medicare ID # _____

FAMILY CAREGIVER NAME (if available)

Address _____

City _____ Zip _____

Phone# _____

Email _____

Relationship to Patient/Client:

Spouse/Partner Child

Other (specify) _____

Date of Birth _____

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

Care Ecosystem (care management for Medi-Cal members)

Other (specify) _____

Additional Information: _____

REQUIRED INFORMATION

Referring Provider Name _____ Title _____

Provider Organization _____

Phone # _____ Email _____