alzheimer's association®

THE BRAINS BEHIND SAVING YOURS.™

Rapid Referral

Partnering with healthcare providers and other organizations to improve care and support for Alzheimer's patients and families.

*This free service offers your patients/clients the benefit of confidential support and information necessary to successfully navigate the challenges inherent with memory loss, Alzheimer's disease and other dementias through **direct referral** to the **Alzheimer's Association Greater Maryland Chapter**.*

***Rapid Referral** provides:*

- ***Education** including dementia symptoms, stages of the disease and other information*
- *Connections to numerous community **resources***
- *Access to **trained clinicians** who can help families navigate through the disease*
- ***Support groups** and **social engagement programs** that provide meaningful interactions*
- ***Support** so that families can more effectively plan ahead, cope and manage*

***Rapid Referral** does not fulfill mandatory legal reporting requirements of healthcare professionals. The Alzheimer's Association Greater Maryland Chapter maintains high professional and ethical standards for care and safety and reports elder and child abuse.*

For additional questions, contact:

Alzheimer's Association Greater Maryland Chapter
Marlyn Taylor, mataylor@alz.org
1850 York Road, Suite D
Timonium, MD 21093
443.632.9719

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Rapid Referral Form

Fax number: 410.561.3433 | Email: info.maryland@alz.org Date: ______________

Name of person with dementia: ______________ *DOB:* ______________

Address: ______________ *City:* ______________ *Zip:* ______________

Phone: ______________ *Email:* ______________

Family member or Personal representative name: ______________ *Relationship:* ______________

Address: ______________ *City:* ______________ *Zip:* ______________

Phone: ______________ *Email:* ______________

Please contact: ☐ ***Person with dementia, or*** ☐ ***Family member/personal representative***

Primary Language: ☐ *English* ☐ *Spanish* ☐ *Other (specify)* ______________

Additional instructions for the Alzheimer's Association in case staff are unable to contact you:

- ☐ *The Alzheimer's Association may leave their organization name and contact name on my voicemail*
- ☐ *Do **not** leave a voicemail*
- ☐ *The Alzheimer's Association may contact me via email or postal mail*
- *Other instructions* ______________

I give permission to the healthcare provider/professional below to forward the information on this sheet to the Alzheimer's Association Greater Maryland Chapter and I understand that a representative from the Alzheimer's Association will contact me.

Signature: ______________ *Date:* ______________
(person with dementia or personal representative)

TO BE COMPLETED BY REFERRING PROVIDER

Diagnosis: ______________ *Diagnosis date (if available):* ______________

Name of provider: ______________ *Title:* ______________

Provider organization: ______________ *Phone:* ______________

Fax: ______________ *Email:* ______________

How would you like to receive follow up? ☐ *Fax* ☐ *Email*

Reason for referral (check all that apply):

- ☐ *Caregiver education*
- ☐ *Clinical trial information (TrialMatch®)*
- ☐ *Healthcare directives*
- ☐ *Information and referrals*
- ☐ *Legal and financial considerations*
- ☐ *Psycho-social consultation*
- ☐ *Safety issues and wandering*
- ☐ *Support groups (early stage/caregiver)*
- ☐ *Other (specify)*

Additional relevant information: ______________