alzheimer's association®

TO: ALZHEIMER'S ASSOCIATION HOUSTON & SOUTHEAST TEXAS

CC: Christina Holch, Healthcare Outreach Manager

FAX: 713.314.1316

DATE: ______________________

FROM: ______________________

Name of individual being referred: ______________________
patient or legally authorized representative

Relationship to person with dementia: ☐ SELF ☐ OTHER: ______________________

I, ______________________
patient name (print)

give the Alzheimer's Association Houston & Southeast Texas Chapter permission to contact me, or the contact person listed below, regarding resources on Alzheimer's services, literature and support groups that are available to help me and my family during this time of need.

Signature: ______________________
patient or legally authorized representative

Phone: ______________________ Email: ______________________

Mailing address: ______________________

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TO BE COMPLETED BY REFERRING PROVIDER

Diagnosis: ______________________ Diagnosis Date: ______________________

Provider Name: ______________________ Organization: ______________________

Provider Phone: ______________________ Fax: ______________________

Reason for Referral (Please check all that apply):

- ☐ Comprehensive Care Consultation
- ☐ Safety issues
- ☐ Legal/Financial
- ☐ Diagnosed individual lives alone
- ☐ Placement
- ☐ Education
- ☐ Difficulty coping
- ☐ Respite/In home caregivers
- ☐ Caregiver stress
- ☐ Early Stage Programs
- ☐ Support Groups
- ☐ Behavioral Issues
- ☐ Medication Management
- ☐ Disease orientation for family/patient

Additional comments: ______________________

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