alzheimer's association

RAPID REFERRAL

No Cover Sheet is Needed

FAX NUMBER: 303-962-9069

DATE:_____

Person to Contact:_____ Phone: _____

E-mail:_____ Zip Code: _____

Language Preference:_____

Please contact within: ☐2-3 Business Days ☐1-2 weeks ☐Other (_____)

☐I am a person diagnosed with dementia.

Or ☐I am a caregiver for a person with dementia.

Person with Dementia's Name: _____

Caller's Relationship to the Person with Dementia: _____

Issue/Concern: ☐Wants General Information ☐New Diagnosis ☐Early Stage ☐Caregiver Stress

☐Other (Specify:_____)

I give my permission to:

Provider Name:_____ Title:_____

Phone: _____ E-Mail/Fax:_____

Give my name and telephone number to the Alzheimer's Association Colorado Chapter, so that a representative from the Chapter can contact me about the support and educational opportunities that are available.

I understand that my name and phone number will not be given to any other agency other than for the purpose stated above. This form will expire on the following date:_____
I understand that I can revoke my permission at any time by contacting the above named referring provider.

Signature: _____ or Verbal Permission Given: ☐

ALZHEIMER'S ASSOCIATION COLORADO CHAPTER
Office: 303.813.1669 Fax: 303.962.9069
24-Hour Helpline 800.272.3900

12/2015