

**Referral Process:**

- Email this form to [directreferralmanh@alz.org](mailto:directreferralmanh@alz.org)
- Fax this form to 617-321-4130
- Refer online through our HIPAA Compliant form at [https://hipaa.jotform.com/ALZ\\_DCC/referralform](https://hipaa.jotform.com/ALZ_DCC/referralform)
- Call Direct Referral Secure Voicemail 617-393-2130

Questions? Email [bpatterson@alz.org](mailto:bpatterson@alz.org)

The clinician making this referral has received permission from their patient or identified primary contact for the information below to be given to the Alzheimer’s Association so that a representative can contact the listed individual regarding support and educational services. The referring clinician has confirmed their patient is a Blue Cross and Blue Shield of Rhode Island Medicare Advantage member and has also *informed* the listed contact that they will be receiving a call from an Alzheimer’s Association representative.

*Completing this form will allow us to more efficiently serve your patient/caregiver.*

Full Name of Patient’s Primary Contact (please print):

\_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_

Relationship to patient (circle) spouse/partner son/daughter grandchild niece/nephew  
other: \_\_\_\_\_

Complete mailing address:

\_\_\_\_\_  
\_\_\_\_\_

Phone Number:

(H) \_\_\_\_\_ (C): \_\_\_\_\_

Email: \_\_\_\_\_

Preferred contact method (circle): H C E Primary Language: \_\_\_\_\_

Patients Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Patients Race/Ethnicity: \_\_\_\_\_

Primary Language (if not English): \_\_\_\_\_

Referring Clinician & Discipline:

\_\_\_\_\_  
\_\_\_\_\_

Medical Clinic/Department: \_\_\_\_\_

Medical Clinic/Department Phone: \_\_\_\_\_

Medical Clinic/Department Fax: \_\_\_\_\_

Email: \_\_\_\_\_

*Please indicate by circling or highlighting how you would like the Care consultation Summary returned to you*

*Please check here if the patient lives with the person being referred*

*Please check here to attest that the patient is a BCBSRI Medicare Advantage member*

Key concerns that should be discussed:

- |   |   |
|---|---|
| <input type="checkbox"/> Behavior management strategies           | <input type="checkbox"/> Caregiver stress                                 |
| <input type="checkbox"/> Disease education                        | <input type="checkbox"/> Communication techniques                         |
| <input type="checkbox"/> Staying home alone                       | <input type="checkbox"/> Driving/transportation options                   |
| <input type="checkbox"/> Management of activities of daily living | <input type="checkbox"/> Housing options: skilled nursing/assisted living |
| <input type="checkbox"/> Care options: adult day health/in-home   | <input type="checkbox"/> Legal & financial/long-term care planning        |
| <input type="checkbox"/> Family dynamics                          | <input type="checkbox"/> General safety tips                              |
| <input type="checkbox"/> Medicare/Medicaid                        | <input type="checkbox"/> Transitioning to long-term care                  |
| <input type="checkbox"/> Geriatric care management                | <input type="checkbox"/> End of life care/hospice                         |

Other Notes:

**Please check this box if the person with dementia would be upset if contacted by the Alzheimer's Association. If checked, the Association will use caution when leaving voice messages and will use blank envelopes for information mailed to the caregiver. The family will not be added to the mailing list without the caregiver's consent.**