RAPID REFERRAL

No Cover Sheet is Needed

FAX TO: **COLORADO CHAPTER HELPLINE**

FAX NUMBER: **719-266-8798 (CO Springs Regional Office)**

DATE:_______________________________________

Participant:____
Please PRINT first and last name to ensure legibility.

_____ **I am a person diagnosed with dementia.**

_____ **I am a caregiver for a person with dementia.**

I give my permission to (referring provider):

Name:________________________________ **Title:**_____________________________

Phone: ______________________ **E-Mail**_________________________________

give my name and telephone number to the Alzheimer's Association Colorado Chapter, so that the Helpline counselor 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: ____

Verbal Permission: _______

Participant Phone (home)_____________________**(work)**________________________

ALZHEIMER'S ASSOCIATION COLORADO CHAPTER
24-Hour Helpline 800.272.3900

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