



RAPID REFERRAL

No Cover Sheet is Needed

FAX TO: COLORADO CHAPTER HELPLINE

FAX NUMBER: 303-813-1670 (Denver Metro 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
Office: 303.813.1669 Fax: 303.813.1670
24-Hour Helpline 800.272.3900**