alzheimer's association

RAPID REFERRAL

No Cover Sheet is Needed

FAX TO: **COLORADO CHAPTER HELPLINE**

FAX NUMBER: **970-259-6055 (Durango 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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