



**RAPID REFERRAL**

**No Cover Sheet is Needed**

**FAX TO: COLORADO CHAPTER HELPLINE**

**FAX NUMBER: 970-346-9025 (Greeley 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**