SNOWLINE DEMENTIA CONNECTION

Dementia Connection Referral Form

Referral Date: _____ Name of Referring Person: _____

Referring Organization: _____

Phone Number: _____ Email: _____

Person Being Referred (name): _____ Phone: _____

Can we call this person directly? Yes ____ No ____ Preferred Method of Contact: Call: ____ Text: _____

Primary Diagnosis of Person: _____

Secondary Diagnosis of Person: _____

Reasons/Concerns for Referral: _____

Primary Point of Contact's Name: _____ Relationship: _____

Phone: _____ Email: _____

Preferred method of contact: Call: _____ Text: _____ Email: _____

____ I would like updates on this person (Release of Information Required).

____ I would prefer that Snowline Dementia Connection follow this person and do not require updates.

____ I acknowledge that the person living in a private home to qualify for this program (skilled nursing facility or residential care facility residents are not eligible).

Living arrangement of person being referred:

____ Lives Alone, Has Caregiver ____ Lives Alone, Has No Caregiver

____ Lives With Caregiver – Caregiver's Relationship to Patient: _____

_____ _____

Referring Person Signature Date

_____ _____

Patient/Caregiver Signature Date

Please email or fax this form to: dementia@snowlinehealth.org or fax to: (530) 622-7032 If you have any questions, please contact the Dementia Connection at the email address above or call us at: Monica Clark, Dementia Connection Intake and Referrals (530) 621-7820. Please properly destroy this referral form or store it in accordance with current HIPPA laws to protect privacy.