DEMENTIA ALLIANCE of North Carolina

A STATE OF CARING

DEMENTIA NAVIGATION

Direct Referral Program

Dementia Alliance of North Carolina partners with healthcare providers and aging service providers to improve the care and support of those living with dementia and their caregivers. Directly refer patients/clients and their caregivers to our Dementia Navigators.

Our Navigators assist with:

- Personalized Recommendations
- Online and Phone consultations
- Information & Referrals
- Educational Materials
- Connections to Support Groups
- Caregiver Assistance Funds

Dementia Alliance has been helping families for over 40 years.
Our mission is to improve the lives of all North Carolinians impacted by dementia, engaging and empowering them through support, education and research.

We value relationships and look forward to partnering with you.

919.832.3732 | DementiaNC.org

Dementia Alliance of North Carolina's Dementia Navigation does not fulfill mandatory legal reporting requirements for healthcare professionals. Dementia Alliance of North Carolina maintains a high professional and ethical standards for care and safety and therefore reports any and all allegations or suspcions of elder abuse and/or child abuse.

DEMENTIA NAVIGATION REFERRAL FORM

Email this form to Dementia Alliance of North Carolina
at info@dementianc.org

Date: _____

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PATIENT/CLIENT NAME

_____

Address_____

City_____ Zip_____

Phone#_____

Email _____

Primary Language:

☐ English ☐ Spanish

☐ Other (specify)

_____

CAREGIVER NAME

_____

Address_____

City_____ Zip_____

Phone#_____

Email _____

Relationship to Patient/Client:

☐ Spouse/Partner ☐ Child ☐ Other _____

Primary Language: ☐ English ☐ Spanish ☐ Other (specify)

_____

I give permission to the referring provider to forward my contact and patient information to Dementia Alliance of North Carolina. I understand that a representative will contact me and/or my caregiver about support, programs, and other services and will follow up with the referring provider. Services are provided virtually and/or in-person.

Referrals will be entered into our secure database, unless indicated otherwise by checking this box ☐

Signature_____Date_____

(Patient/Client or Personal Representative/Family Caregiver)

The person being referred provided verbal consent in stead of signature: ☐ Yes

REASON FOR REFERRAL (check all that apply)

☐ One to One Dementia Education & Support
☐ Recent Diagnosis
☐ Support Groups
☐ Safety Issues
☐ Respite Services
☐ Caregiver Education/Workshops
☐ Other (specify)_____

Additional Information: _____

_____

_____

REQUIRED INFORMATION

Referring Provider Name _____ Title _____

Provider Organization _____

Phone # _____ Email _____