Center of Excellence for Alzheimer's Disease

Referral

Please complete form and fax information to:

CEAD WNY Intake

Fax: (716) 859-7701

Date: ___ / ___ / _____ Referring Provider:_____ Phone: (____) ____ - _____

Patient: _____ Age: ____ Sex: Diagnosis: _____

Address: _____ City: _____ Zip Code: _____

Phone: (____) ____ - _____ Okay to leave message?

Caregiver: _____ Phone: (____) ____ - _____ Lives with patient?

Relationship to patient: _____ Person to contact:

Medical Managment Services:

- ☐ **Referral to Alzheimer's Disease & Memory Disorders Center**
- ☐ **Referral to VA Geriatric Evaluation & Management Clinic**
- ☐ **Behavior Management**
- ☐ **Dementia related ED visit Avoidance**
- ☐ **Home Visit by CEAD NP may be arranged on a case by case basis**
- ☐ **Management of Co-Morbid Diagnosis**
- ☐ **Medication Reconciliation**
- ☐ **Palliative Care Consultation**
- ☐ **Recurrent Readmission Avoidance**
- ☐ **Referral to Clinical Trials**

Other(s):

Supportive Services:

- ☐ **Care Consultation**
- ☐ **Counseling**
- ☐ **Diagnostic Process Education**
- ☐ **Disease Information**
- ☐ **Family Consultation**
- ☐ **Referral to Community Resources**

I give permission for the referring provider to give my name, contact information and patient information to the Center of Excellence for Alzheimer's Disease of Western New York so that a staff member may contact me or my personal representative. I understand the health information listed above may not be further used or disclosed unless another authorization is obtained by me or unless such use or disclosure is required or permitted by law.

Signature: _____■

Check if verbal permission was given in lieu of signature:

Center of Excellence for Alzheimer's Disease P: (716) 859-7498 F: (716) 859-7701

This program is supported by a grant from the New York State Department of Health