Provider Referral Form

Please complete and fax form to our office.

Date: _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Caregiver Name: _____ Primary Caregiver? Y / N

Phone: _____ Email: _____ Preferred Contact Method: Phone or Email

Address (if different): _____ City: _____ State: _____ Zip: _____

Provider Information:

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

By completing and signing this form, you are referring this person and their caregiver to Alzheimer's & Dementia Services of Northern Indiana for the follow services but not limited to:

- AMPLIFY life
- Recreational Therapy Screen*
- Life Story Creation
- Support Groups
- Crisis Planning
- Care Coaching
- Respite Assistance
- Active Memory Programs such as Expressive Arts, Fitness, Socialization, & Spirituality
- Health Aging Brain Care Monitoring

**Needs physician order*

Provider Signature: _____ Date: _____

Alzheimer's & Dementia Services of Northern Indiana

Care Connections
111 Sunnybrook Court
South Bend, IN 46637

888.303.0180 Toll-Free
574.232.4121 Office
574.566.1362 Fax

Alzheimer's & Dementia Services
OF NORTHERN INDIANA
powered by REAL Services