Dementia Support Services

Services provided by the
Alzheimer's Coalition of Henderson County

Referral Form

**IMPORTANT NOTE: Before giving out these information packets on Alzheimer's disease or a related dementia to your patients, please have the patient fill out the information below and sign the form.

Please fax to 903.904.5123

Today's Visit Date: ____________________

Patient's Name: ____

Caregiver's Name: ____

Address: ____

City: ____________________ State: ________ Zip: ____________

Telephone #: ______________ Email Address: ______________________________

DOB: ___/___/___ Age as of today: _______
mm dd yy

Type of dementia: _______________________________

Has the patient been referred to a neuropsychologist? Yes No

Patient's Signature: ____

Referring Physician/Nurse Practitioner/Staff: ____________________________

Contact Phone for referral source: ______________________________________

For Office use only: ☐ Entered _________________ (Date)

For questions, please contact Stephani Neal at alzcoalitionhendersoncotx@outlook.com