caringkind
The Heart of Alzheimer's Caregiving

CaringKind Connection

No cover sheet necessary

EMAIL: helpline@cknyc.org

Date: _____

Caregiver Name: _____ **DOB:** _____ **Gender Identity:** □ M □ F □ T
(Please **PRINT** first and last name)

Relationship: □ Spouse/Partner □ Daughter/Son □ Sister/Brother □ Grandchild □ Other: _____

Person with Dementia: _____ **DOB:** _____ **Gender Identity:** □ M □ F □ T
(Please **PRINT** first and last name)

Diagnosis: □ Dementia □ Alzheimer's disease □ Lewy Body dementia □ Vascular dementia

□ Mild Cognitive Impairment □ Other _____ **Date of Diagnosis:** _____

Who should we contact: □ Caregiver □ Person with Dementia

Best time to call: □ Morning □ Afternoon

Preferred language: □ English □ Spanish □ Chinese □ Other: _____

Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Phone: _____ **Email Address:** _____

I give permission to my service provider to give my name and contact information to CaringKind. I understand that a CaringKind Helpline Specialist will contact me about the free support and educational services that are available. I understand that my name, contact information or health information listed above will not be disclosed or shared with any other entity unless authorization from me is obtained. I understand that I can revoke my permission at any time by contacting the referring provider named below. I also give permission to CaringKind to follow up with the provider named below.

Signature (*To be signed by the person to be contacted):* _____

The person being referred provided verbal consent instead of a signature □ Yes

TO BE COMPLETED BY REFERRING PROVIDER:

Referring Person/Agency: _____

Phone: _____ **E-mail:** _____

Services requested: □ Information & Referral □ Consultation (counseling/care planning/advocacy)
□ Wanderer's Safety Program □ Education □ Support Group

FOR INTERNAL USE ONLY:

Dept:	Date:	Outcome:			Staff:
□ AA	_____	□ Completed	□ LVM	□ NoVM	_____
□ CH	_____	□ Completed	□ LVM	□ NoVM	_____
□ LTO	_____	□ Completed	□ LVM	□ NoVM	_____
□ MHC	_____	□ Provider Follow - up			_____