caringkind
The Heart of Alzheimer's Caregiving

CaringKind Connection

Fax: 212-697-6158 **Email:** Helpline@cknyc.org

Date: _____

CARE/SUPPORT PARTNER: _____
(Please **PRINT** first and last name)

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Other: _____ **Second Language:** _____

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

Phone: _____ **Email Address:** _____

Street: _____ **City:** _____ **Zip:** _____

PERSON WITH MCI/DEMENTIA: _____ **DOB:** _____
(Please **PRINT** first and last name)

Gender: ☐ F ☐ M Prefer to self-describe: _____**Preferred Language**: ☐ English ☐ Spanish ☐ Chinese ☐ Other: _____

Cognitive Status: MOCA: _____ **MMSE:** _____ **SLUMS:** _____ **Other Testing:** _____

Diagnosis: ☐ Mild Cognitive Impairment ☐ Alzheimer's Disease ☐ Lewy Body dementia ☐ Vascular dementia

☐ Mixed dementia ☐ Frontotemporal Degeneration ☐ Other: _____ **Date of Diagnosis:** _____

Living Situation: ☐ Lives alone ☐ Lives w/caregiving partner/spouse ☐ Lives w/other caregiver ☐ Lives w/other non-caregiver

Phone: _____ **Email Address:** _____

Street: _____ **City:** _____ **Zip:** _____

Best Person to Contact: ☐ Person w/MCI/Dementia ☐ Care/Support Partner. **Preferred Method of Contact:** ☐ Phone ☐ Email

I give permission to CaringKind and the service provider below to exchange contact and health information for the person with MCI/dementia and/or care/support partner named above in order to provide dementia education, information and support related to the coordination of care. I understand that a CaringKind Specialist will contact me about services and programs that are available. I understand the contact and health information provided will not be disclosed or shared with any other entity unless authorization from the listed parties is obtained. I understand this permission can be revoked at any time by contacting CaringKind and/or the referring provider named below. ***Person referred provided verbal consent instead of a signature ☐ Yes***

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

TO BE COMPLETED BY REFERRING PROVIDER:

Referring Person/Agency: _____

Phone: _____ **Email Address:** _____

Specific Needs/Concerns:_____

_____

_____

Recommended Programs and Services (check category and/or specific service/program):

☐ MCI/Dementia Client Services & Programs	☐ Family Care Partner Support & Education
☐ Early-Stage Group Programs ☐ Cognitive Stimulation Therapy ☐ MAP Volunteer Matching Program ☐ Support Group	☐ Education ☐ Consultation/Coaching ☐ Support Group ☐ Wanderer's Safety Program