Step-by-step instructions for filling out the DCC referral letter in Epic for Advocate Health, Midwest Region (IL & WI)

Aligned providers (APP) without Epic access can fill out the PDF attached to the last page.

EPIC: Health care clinician selects a new communication

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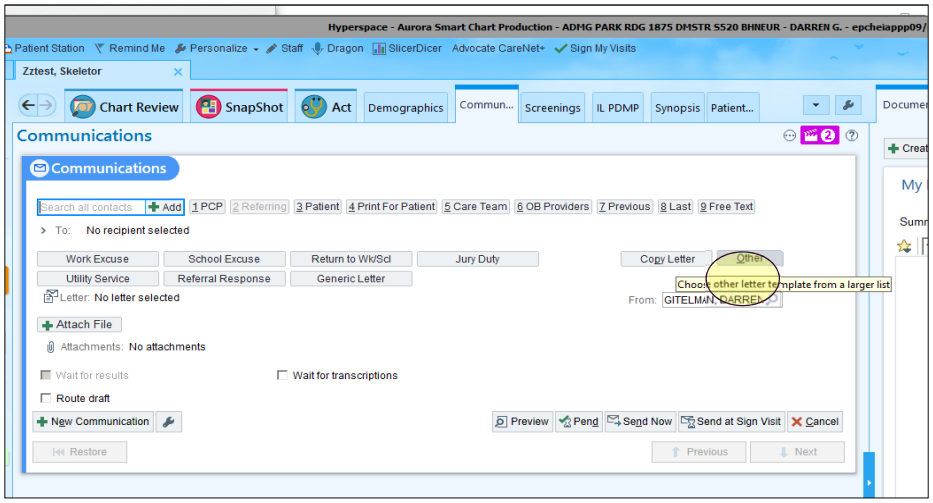
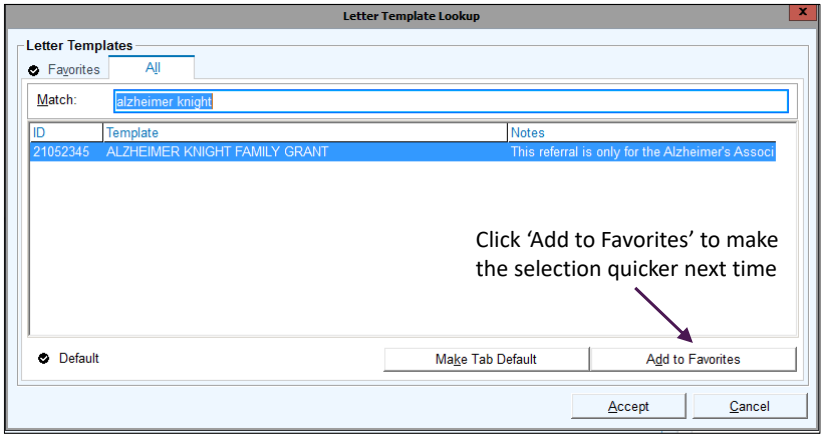
EPIC: Choose a letter type of Other

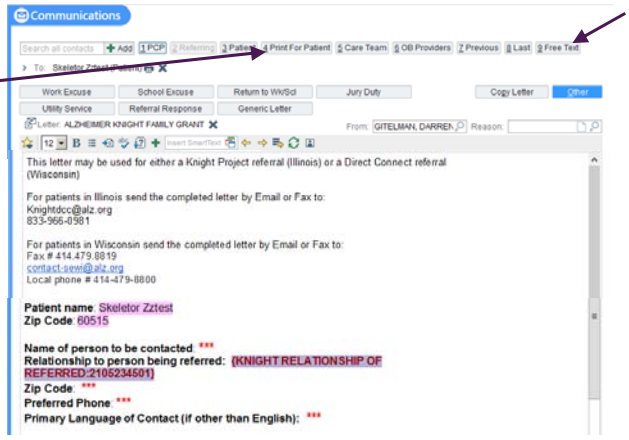


EPIC: To find the letter template: Enter "Alzheimer Knight" in the search box and click Accept

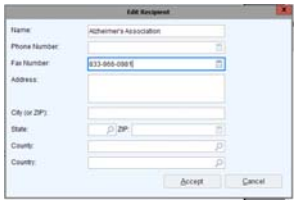


EPIC: Fill in the required information and then send the form to the Alzheimer's Association. There are 2 ways to send the form. Choose the way that is best for your workflow.

1) Print and Fax:
Choose the "Print for Patient" button. Once the information has been filled in, the letter can be printed and manually faxed to the Alzheimer's Association



2) Fax from Epic:
Choose the "Free Text" button. Enter Alzheimer's Association for the name, and the correct fax number as listed in the letter for IL or WI. Click Accept and then send immediately or after the visit is signed.



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EPIC: Complete the letter: Items in green are filled in by the system. Items in yellow the clinician fills in. (These colors are not actually visible in the letter.)

Patient name: @NAME@
Zip Code: @ZIP@

Name of person to be contacted: ***
Relationship to person being referred: {KNIGHT RELATIONSHIP OF REFERRED:2105234501} (e.g., spouse, adult child, etc.)
Zip Code: ***
Preferred Phone: ***
Primary Language of Contact (if other than English): ***

May we identify as the Alzheimer's Association when we call? {YES DEFAULT YES:143722} (Yes / No)
May we leave a voicemail message? {YES DEFAULT YES:143722} (Yes / No)

I give permission to my healthcare or service provider to fax or e-mail my personal health information including my name and contact information, to the Alzheimer's Association. I understand that an Alzheimer's Association Helpline representative will contact me about support and educational opportunities. In addition to giving my permission to be contacted by the Alzheimer's Association, I give permission for the Alzheimer's Association to share a summary of our discussion with the referring provider as indicated above. I understand this is a free service provided by the Alzheimer's Association. I understand that my name, contact information and other health information will not be disclosed or shared with any other entity unless authorization is obtained from me.

Signature: _____ Date: _____

The referred person provided verbal consent instead of their signature: {KNIGHT VERBAL CONSENT:2105234503} (Yes)

Health Care professional name: @MECRED@
HCP organization:
@LOGINDEP@

Health Care Provider Comment (option ***

Make sure the patient signs the letter or gives their verbal consent [select Yes if consent is given]. Please do not send the letter without getting consent.

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EPIC: Send the form to the Alzheimer's Association

- Once the letter is filled out, print and fax it or fax it directly.
  - Make sure all the required elements have been filled in, including consent (verbal or signature)
- For patients in **Illinois** send the completed letter by fax or encrypted email to:
  - Fax: 833-966-0981
  - Scan and email the letter to: knightdcc@alz.org
- For patients in **Wisconsin** send the completed letter by fax or encrypted email to:
  - Fax: 414.479.8819
  - Scan and email the letter to: contact-sewi@alz.org

Non-EPIC instructions for aligned clinicians: Dementia Care Coordination Fillable Form

(Double click the form below to open it)


alzheimer's association

Dementia Care Coordination Referral Form

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In Illinois: Email this form to knightdcc@alz.org
Or Fax form to: 833-966-0981

In Wisconsin: Email the form to contact-sewi@alz.org
Or Fax form to: 414-479-8819.

Dementia Care Coordination Referral Form

Name of person being referred:	**Zip Code:**
Name of person being contacted (if not the person being referred):	**Zip Code:**
Relationship to person being referred: ☐ Self ☐ Spouse/Partner ☐ Son/Daughter ☐ Grandchild ☐ Niece/Nephew ☐ Friend ☐ Other (specify)_____	
Preferred Phone:	**Preferred email:**
Primary language (if other than English):	

I give permission to my healthcare or service provider to fax or e-mail our name and contact information to the Alzheimer's Association. I understand that an Alzheimer's Association Helpline representative will contact me about support and educational opportunities. In addition to giving my permission to be contacted by the Alzheimer's Association, I give permission for the Alzheimer's Association to share a summary of our discussion with the referring provider as indicated below. I understand this is a free service provided by the Alzheimer's Association. I understand that our name, contact information or health information listed above will not be disclosed or shared with any other entity unless authorization is obtained by me.

Signature:_____ **Date:** _____

The person being referred provided verbal consent instead of their signature: ☐ **Yes**

May we identify ourselves as the Alzheimer's Association when we call? ☐ Yes ☐ No
May we leave a voicemail message? ☐ Yes ☐ No

To be completed by the healthcare professional

Healthcare provider name:	
Healthcare provider organization and department:	
Healthcare provider fax number:	**Email:**
Additional comments (optional):	

In Illinois: Email this completed form to knightdcc@alz.org or fax form to: 833-966-0981.

In Wisconsin: Email this completed form to contact-sewi@alz.org or fax form to: 414-479-8819.