Caregiver Fax Referral

Fax: 912.303.0242

Attn: Jill Costello

Caregiver / Care Recipient

I give permission to my care recipient's health care professional, _____, to give my name, address, phone number, and the below client information to the Edel Caregiver Institute. This is to permit a representative from the Edel Caregiver Institute to contact me with information on support and support groups, educational opportunities, and other resources involving caregiving. I understand that if necessary, the Edel Caregiver Institute will provide feedback to this health care professional based upon our contact. I also grant permission for the Edel Caregiver Institute to inform care recipient's physician about the services received.

Signature: _____

Please print name: _____

Relationship to Care Recipient: _____

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

To Be Completed By Healthcare Professional

Name of Caregiver: _____ Age:_____

Name of Care Recipient: _____ Age: _____

Diagnosis: _____

Greatest Concern: _____

_____

_____

_____

Health Care Professional Information

Name: _____

Organization: _____

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