REFERRAL IS EASY

1. Use the CJD Foundation referral form

2. Fax or e-mail completed and signed referral forms to the CJD Foundation

3. A Helpline consultant will contact your client to answer questions, offer support and make necessary referrals.

Rapid Referral is an easy way to link families to a Helpline consultant. This free service offers your clients the benefit of confidential support and information necessary to navigate the non-medical challenges inherent in caring for a loved one affected by a prion disease.

Referral to the CJD Foundation is a benefit to families that you can add to your service package. This referral will provide a much needed connection for caregivers.

To learn more about the Rapid Referral program please contact us at 1-800-659-1991.

Our Mission

The mission of the CJD Foundation is to create and promote comprehensive and humane care for patients and families affected by prion diseases. We provide support for patients, their families and professional caregivers, and also support the development of treatments and a cure for prion diseases through the advancement of research. We meet this mission through increasing public awareness, providing education, creating and encouraging collaboration with researchers, and conducting advocacy.

RAPID REFERRAL

No Cover Sheet is Needed

FAX or E-MAIL TO: The Creutzfeldt-Jakob Disease (CJD) Foundation

FAX NUMBER: 234-466-7077

EMAIL ADDRESS: help@cjdfoundation.org

DATE: ____________________

I, ____
Please PRINT first and last name to ensure legibility

Address: ____

Phone (home) ____________________ (cell/ work) _______________________

I am a caregiver for a person with a suspected prion disease and give my permission to the referring provider named below to give my name and telephone number to the CJD Foundation so that a Helpline consultant can contact me about the free support and educational services that are available.

Health Care Provider: ______________________________

Title: ___________________________

Phone (office) ______________________

E-Mail: ____________________________

I understand that my name and phone number will not be given to any other agency other than for the purpose stated above.

I understand that I can revoke my permission at any time by contacting the above named referring provider.

Signature: ____