GWEP REFERRAL
Research Interest Form

Physician/GWEP Staff,

Please have your patient complete this form so that we can follow-up with him or her.

Thank you.

Dear Potential Research Participant or family member,

Please complete the form below. Make sure to give us the best contact information so that we can reach you.

Thank you and look forward to speaking with you.

Sincerely, Alzheimer Disease Research Center Staff

Name of potential research participant:___________________________________________________________

Name of a contact person, if appropriate, such as a family member or close friend (who is not the potential research participant):___________________________________________________________

Phone number:___________________________________________________

Email:______________________________________________________________

Best time and way to reach you: _____________________________________________________________

Name of Referring Physician: _________________________________________________________________

Additional Comments:__________________________________________________________________________

__________________________________________________________________________________________

ADRC PHONE: (323) 442-7600                      ADRC FAX: (323) 442-7601