# Sequoia Pathways: Dementia Education & Support

Patient Consent Form

The Sequoia Pathways Dementia Education & Support Program is designed to provide comprehensive evaluation, education, and support services for individuals living with dementia and their caregivers. This form outlines the purpose of the program, services provided, and your rights as a participant.

## Program Description

As part of the program, you or your loved one may receive:

- Comprehensive dementia assessment (medical history, cognitive and functional assessments)
- Ongoing visits and follow-ups with dementia-trained providers
- Care planning, medication review, and behavioral management strategies
- Caregiver education and support resources
- Coordination with other healthcare providers and facility staff

## Consent

By signing this form, I acknowledge and consent to participate in the Sequoia Pathways Dementia Education & Support Program. I understand that participation is voluntary and that I may withdraw at any time without affecting my medical care.

I consent to the following:

☐ Participation in dementia assessment and care planning

☐ Review and management of current medications

☐ Communication between Sequoia providers and my primary care/facility staff as needed

☐ Use of program tools and resources for caregiver education and support

☐ Collection of outcome data (e.g., caregiver satisfaction, functional assessments) for quality improvement purposes

## Confidentiality

All information shared within the program will be kept confidential in accordance with HIPAA regulations. Your health information will only be shared with your permission or as required by law.

## Patient Rights

- You have the right to withdraw from the program at any time.
- You have the right to ask questions and receive clear explanations.
- You have the right to confidentiality regarding your health information.
- You have the right to receive copies of this consent form.

## Acknowledgment & Signature

Patient/Legal Representative Name: _____

Signature: _____ Date: _____

If signed by Legal Representative, relationship to patient: _____

**For questions about this program, please contact us at (920) 422-7402.**