618-9th Street North, Kenora, Ontario P9N 2S9 Tel: (807) 468-1516 Fax: (807) 468-9013 alzheimer.ca/en/krr

(Due to confidentiality referrals can only be faxed).

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Date of Referral:	
Person with Dementia Name (probable or diagnosed): (First name, Last name)	
Diagnosis & Date of Diagnosis (if known):	Specify
Under Investigation	here:
Date of Birth (mm/dd/yy):	Address:
Telephone Number:	
Can a voicemail message be left: Yes No	E-mail Address:
Preferred Language of Choice for Service: English	French Other:
Care Partner Name: (First name, Last name)	Relationship to above:
Date of Birth (mm/dd/yy):	Address: Same as above Other, please specify:
Telephone Number:	
Can a voicemail message be left: Yes No	E-mail Address:
Preferred Language of Choice for Service English	French Other:
Referral Source Name & Agency:	Address: Phone: Fax: Email:
I have received consent to refer Yes No	Please only include OHIP of referred persons:
l am referring: Person with Dementia Care Partner	Both Care Partner OHIP#:
Please contact: Person with Dementia Care Partner	Both Person w/Dementia OHIP#:
Reason for Referral  Cognitive Assessment Emotional Support Information/Education Finding Community Supports	

Cognitive Assessment Emotional Support Information/Education Finding Community Supports
Recently Diagnosed Changes in Behaviour Safety Concerns Staying Socially/Physically Engaged
Living Arrangement/Transition Support Other/Specific Program, please specify:

Additional Notes:

**Known Risks:** Yes No If yes, please select all that apply:

Family dynamics Infectious diseases Infestation/Squalor Pets Physical Environment

Recent hospitalizations Responsive behaviours Smoking Weapons Other: