Société Alzheimer Society

Referral form Fax 613-932-6154

Are the persons referred aware that the Alzheimer Society will be contacting her/him?

Caregiver: Yes No Client: Yes No

1. Caregiver Information

Name: _____Relationship:_____

Address: _____City_____

Postal Code: _____Date of Birth: _____

Health Card #: _____ E-mail:_____

Telephone (home): _____ (work): _____

Language Preferred: English French Other

Other Agency Involvement: _____

POA: personal care _____ property _____ both: ____ GP: _____

2. Person Living with Dementia Information

Name: _____ Relationship: _____

Address: _____City: _____

Postal Code: _____Date of Birth: _____

Health Card #: _____E-mail: _____

Telephone (home): _____ (work): _____

Language Preferred: English French Other

Diagnoses: _____Diagnoses date : _____

Is the client aware of their diagnosis? yes no

Family Physician: _____

3. Reason for referral - (Please check the priority presenting issue(s).)

Information on Diagnosis

ADL's IADL's Caregiver Stress Medical Condition Symptom management Diagnosis

Links to Services

☐ Peer Support ☐ Respite and Relief ☐ Respite & Activation:
MIM ___ DSP ___ Ipod ___

☐ Safely Home ☐ First Link Partnership in transitional care

☐
Education Support\Counselling Community Resources

Other _____

Risks

☐Abuse ☐ Driving ☐ Living Alone ☐ Safety ☐ Wandering

4. Referring Source

Referred By: _____ Date: _____

Referring Agency: _____ Telephone #: _____

Email : _____ Fax #: _____

For Alzheimer Society Only Caseworker Name: _____

Date Contacted:_____1. **File # _____2. File # _____**

Comments: _____

_____