Alzheimer Society
DUFFERIN COUNTY

First Link® Premier lien®

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www.alzheimer.ca/dufferincounty

Date of Referral:

Person with Dementia Name (probable or diagnosed):
(First name, Last name)

Diagnosis & Date of Diagnosis (if known): Specify here:

Under Investigation

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:
I 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
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:

Please send supplemental documentation as appropriate.