

# Société Alzheimer Society

NEW BRUNSWICK / NOUVEAU-BRUNSWICK

## U-First!® for Care Partners Referral Form

### Client Eligibility Criteria

Please select all that apply.

This referral client:

- ☐ Directly supports an individual experiencing behavioral changes due to dementia or other cognitive impairment in an unpaid role.
- ☐ Has participated in other dementia education programs and has a basic understanding of dementia and its symptoms.
- ☐ Is able to attend a full workshop, which will be offered as either two 3.5-hour sessions or one 7-hour session. *Virtual and in-person workshops will be offered.*
  - Please note that ASNB can cover respite costs, up to \$160, for those who need to arrange alternate care for the person living with dementia while they attend the workshop.
  - Please outline any potential barriers to participation (mobility, availability, transportation, family responsibilities, etc.):
- ☐ Has access to a personal computer or tablet, a stable internet connection, a working microphone, and a private/quiet location (for virtual workshops).
  - If not, please describe limitations:
- ☐ Is willing to provide feedback regarding their U-First!® experience (Optional, but highly encouraged).

### Client Information:

| Family member or care partner   | Person living with dementia          |
|---|--------------------------------------|
| Name:   | Name:                                |
| Relationship to person living with dementia:  | Diagnosis:<br><br>Date of Diagnosis: |
| Municipality:   | Municipality:                        |
| Gender:   | Gender:                              |
| Resides with person living with dementia?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Year of Birth:                       |

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## Contact Information:

Preferred method of contact: ☐ Email ☐ Phone

Preferred language of contact: ☐ English ☐ French

Email:

Phone:

*For phone communications:*

Best time to call? ☐ Morning ☐ Afternoon

May we leave a message? ☐ Yes ☐ No

Would the family member or care partner like to learn about other programs and services offered by the Alzheimer Society of NB? ☐ Yes ☐ No

## Notes:

Referral made by:

Organization (if applicable):

Referrer contact information (phone and/or email):

## Statement of consent:

*This may be signed on behalf of the referral client(s) by the referral partner with verbal consent.*

By signing below, I give permission to the Alzheimer Society of New Brunswick to:

- a) Contact me and provide information about U-First!® for Care Partners as well as other programs and supports that may benefit me and my family
- b) Tell the person who is referring me to the Alzheimer Society whether or not I have been contacted.

I have read, understand, and agree to the terms listed in the above statement of consent.

**Name:**

**Date:**

To submit your referral form, please email your completed form to [education@alzheimernb.ca](mailto:education@alzheimernb.ca) or mail to:

Alzheimer Society of NB

Attn to: Nicole Legere

320 Maple Street, Suite 100, Fredericton, NB E3A 3R4

**Thank you for your referral and for helping to promote this training opportunity.**