

**Date of Referral:**

**Person with Dementia Name (probable or diagnosed):**

(First name, Last name)

Diagnosis & Date of Diagnosis (if known):

Under Investigation

Specify 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:

**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**

Recently Diagnosed

Emotional Support

Information/Education

Finding Community Supports

Living Arrangement/  
Transition Support

Changes in Behaviour

Safety Concerns

Staying Socially/Physically Engaged

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.**