First Link | Premier lien

Société Alzheimer Society
CORNWALL & DISTRICT
CORNWALL ET DISTRICT

First Link Referral Form

Cornwall
Fax: 613-932-6154
Phone: 613-932-4914
Email: alzheimeredcoord@one-mail.on.ca
Hawkesbury
Fax: 613-632-5189
Phone: 613-632-4349

Date:___________________________________

Referral Source Information:

Name:___________________________________ Title:___________________________________

Organization/Agency:___________________________________

Address:___________________________________
Street City Postal Code

Phone#:_______________ Fax#:_________________ Email:___________________________

Client Information (Person with Dementia):

Name: ___________________________________ DOB: ___________________________________

Address: ___________________________________ Phone #:___________________________________

Living Alone: ❒ Yes ❒ No ❒ Male ❒ Female

Diagnosis: ___________________________________ Diagnosis Date:___________________________
(Alzheimer's disease, Vascular, FTD)

Family Physician:___________________________________ Phone #:___________________________

Contact Person Information (*If different than above)

Name: ___________________________________ Phone #:___________________________________

Address: ___________________________________
Street City Postal Code

Relationship to PWD: ❒ Spouse ❒ Child ❒ Other:___________________________
Please specify

❒ Male ❒ Female Year of Birth_______________

Language: ❒ English ❒ French ❒ Other___________________________________

Period of wait time preferred:

❒ Adjusting to diagnosis – Minimum of three weeks ❒ Requesting support ASAP

May leave message? ❒ Yes ❒ No

Comments:

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A First Link™ Intake Coordinator will be contacting the above named contact person to discuss the First Link™ community of learning, services and support.

Revised: October 2011