ALZHEIMER SOCIETY Lanark Leeds Grenville

REFERRAL FORM

Please **fax** completed form to Alzheimer Society Lanark Leeds Grenville 613-345-3186.

Questions? Call 613- 345-7392 or Toll Free 1-866-576-8556

**DATE OF REFERRAL:** Click to choose date **CAREGIVER:** Click or tap here to enter text.

Address:Click or tap here to enter text.

D.O.B. Click or tap to enter a date. Health Card #Click or tap here to enter text.

Tel:(H) Click or tap here to enter text.(W) Click or tap here to enter text. (C)Click or tap here to enter text. Leave Message

E-mail: Click or tap here to enter text.Relationship to Person with Dementia:Click or tap here to enter text.

**Person with Dementia:** Click or tap here to enter text.D.O.B. Click or tap to enter a date.

Address: Click or tap here to enter text.Same as Caregiver

Tel:Click or tap here to enter text.  Same as caregiver

Health Card #Click or tap here to enter text.

Family Dr:Click or tap here to enter text. Specialist: Click or tap here to enter text.

Living arrangements:

Alone

With Family

☐ Retirement Home

Other Click or tap here to enter text.

**Diagnosis:** Alzheimer’s disease  Vascular dementia  Mixed Dementia Other:Click or tap here to enter text.

Date of diagnosis:Click or tap to enter a date. Diagnosis shared with client/caregiver

**ADDITIONAL INFORMATION:** Click or tap here to enter text.

**Other contacts:**

Name:Click or tap here to enter text. Relationship to PWD:Click or tap here to enter text.

Phone:Click or tap here to enter text.

**Referral Source:**

Name: Click or tap here to enter text. Position: Click or tap here to enter text.

E-mail:Click or tap here to enter text.

Phone #:Click or tap here to enter text.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_