Société Alzheimer Society

NOVA SCOTIA

Date: _____

For office use only
Ref entered: _____
Date (D/M/Y): _____

First Link® Referral Program

The First Link® Referral Program provides an opportunity for physicians and health care providers to refer a person with cognitive impairment or a diagnosis of dementia, and/or those who support them to the Alzheimer Society for information, support and education.

Referral by:

Note - Only **name** and **clinic** required on second and subsequent referrals

Name: _____ Title/Profession: _____

Organization: _____ Clinic: _____

Address: _____ Town/City: _____

Phone: _____ Email: _____ Fax: _____

Please contact:

Only refer one person per form

☐ Person with dementia

☐ Caregiver (Partner in care)

Consent of person to be contacted:

I consent to be contacted by the Alzheimer Society of Nova Scotia.

Signature: _____

Date: _____

In lieu of written consent, verbal consent was received:

☐ Yes ____ (initials)

Caregiver information:

Name: _____

☐ Spouse ☐ Other family member ☐ Friend ☐ Other

Town/City: _____

Daytime Phone: _____

May we leave a message?: ☐ Yes ☐ No

Person with dementia information:

Name: _____

☐ Person with cognitive impairments
☐ Diagnosed with dementia

Town/City: _____

Daytime Phone: _____

May we leave a message?: ☐ Yes ☐ No

Reason for referral/Comments:

Is this a recent diagnosis? ☐ Yes ☐ No

_____

_____

Forward referral information by fax: 902-406-6890

We attempt to call clients within 3 weeks of referral. Contact sooner? ☐ Yes ☐ No

Request phone confirmation that referral was received? ☐ Yes ☐ No

Request follow up report? ☐ No ☐ Yes If yes: ☐ Fax ☐ Mail

The Alzheimer Society adheres to professional standards for confidentiality and security of personal information in accordance with provincial and federal legislation.

Alzheimer Society of Nova Scotia, 112-2719 Gladstone Street, Halifax, NS B3K 4W6
902-422-7961 • First Link Fax 902-406-6890
www.alzheimer.ca/ns