

Client Referral Form

Steps to make a First Link Referral: Ask for permission to forward individual's name to the Alzheimer Society of York Region. Complete form, print and either e-mail or fax.

Send printed forms to:

Fax: 905-726-1917

Alzheimer Society of York Region
 2-240 Edward Street
 Aurora, ON L4G 3S9
 905-726-3477

OR email saved form to: smaclean@alzheimer-york.com

Client/Patient Info

Name: _____	Gender _____	Click the down arrow. _____
Address: _____	Date of Birth: _____	_____
City: _____	Family Doctor: _____	_____
Postal Code: _____	Diagnosis: _____	_____
Phone #: _____	Diagnosis Date: _____	_____

Caregiver/Contact Info

Name: _____	Relationship to Patient: _____
Address: _____	
City: _____	FIRST LINK FOLLOW UP
Postal Code: _____	Preferred Contact Person: _____
Home. Phone: _____	Preferred Contact Method: _____
Cell Phone: _____	Preferred Contact Time: _____
E-mail: _____	Can a message be left? <input checked="" type="radio"/> Yes <input type="radio"/> No

Referred By

Name: _____	Agency/Org: _____
Address: _____	Fax Number: _____
City: _____	Bus. Phone: _____
Postal Code: _____	E-mail: _____

Reason for Referral

Please Support: Client Caregiver

 Please Contact: Urgent (< 1 week) Non-Urgent

Notes:
