First Link® Premier lien™

Alzheimer Society of Simcoe County
REFERRAL FORM

Please fax to (705) 722-9392

For information about this referral call (705) 722-1066

Date of referral:

Client/Patient Information (Person Living with Dementia)

Name: DOB (mm/dd/yyyy):

Diagnosis & Date of Diagnosis (if known):

Diagnosing Physician: Family Physician:

Primary Contact Information (Care Partner, Family, Friend, Substitute Decision Maker)

Name: Phone Number:

Address:

City: Postal Code:

Gender: DOB (mm/dd/yyyy):

Relationship: Person Living with Dementia ☐ Spouse ☐ Adult Child ☐ Other:

Communication Limitations: No Messages ☐ Email Preferred ☐

Consent Obtained From: Client/Patient ☐ Substitute Decision Maker ☐

Additional Comments (other pertinent information i.e. living arrangements, driving, family dynamics, etc.):

Referral Source (please provide your name/organization)	**Telephone**	**Fax**

Requested Alzheimer Society Service (Please check all that apply)

- ☐ **Education for Primary Contact**
- ☐ **Education for Client/Patient** (opportunity to learn and share with others who are in the early stages of dementia)
- ☐ **Care Partner Support Groups**
- ☐ **Family Support Coordinator:** Supportive counselling provided in a face-to-face visit or by telephone
- ☐ **Information Package**

Referral Urgency Checklist (Please check all that apply)

- ☐ The person with dementia is living alone with risk e.g. fire, neglect, wandering
- ☐ There is a presence of responsive behaviour, **without** immediate risk of harm.
- ☐ The family or friend is at risk of harm or uses language to indicate grief, being overwhelmed or not coping.
- ☐ The family or friend and/or person living with dementia is in the midst of critical decision making and it is time sensitive.
- ☐ Other

Alzheimer Society SIMCOE COUNTY

For office use only:
Letter Sent to Referral Source ☐ Date Sent:
N/T #: