First Link Premier lien

First Link ™ Referral Form

Fax: Muskoka (705) 645-4397

Referral Source Information

Name:

Title: Date:

Type of Practice/Community Partner

Family Health Team:	Community Health Centre	Memory Disorder Clinic	
Private Practice	Community Care Access Centre	Geriatrician	Other
Discipline/Role:	Family/Physician/GP	Allied Health Professional	Specialist

Address:

Phone#: Fax#: E-Mail:

Patient Information

Name: DOB:

Address: Phone #:

Gender: Language: Does the patient live alone: Yes No

Diagnosis: DX Date:

Diagnosing Physician: Family Physician:

Contact Information

Name: Phone #:

Address:

Relationship to person with dementia: Spouse Child Other

Period of wait time preferred:

Time to adjust to diagnosis (minimum four weeks) Request support ASAP

Additional Comments: