

**Date of Referral:**

**Person with Dementia Name (probable or diagnosed):**

(First name, Last name)

Diagnosis & Date of Diagnosis (if known):

Under Investigation

Specify here:

Date of Birth (mm/dd/yy):

Address:

Telephone Number:

Can a voicemail message be left:    Yes    No

E-mail Address:

Preferred Language of Choice for Service:    English    French    Other:

**Care Partner Name:**

(First name, Last name)

Relationship to above:

Date of Birth (mm/dd/yy):

Address:    Same as above    Other, please specify:

Telephone Number:

Can a voicemail message be left:    Yes    No

E-mail Address:

Preferred Language of Choice for Service    English    French    Other:

**Referral Source Name & Agency:**

Address:

Phone:

Fax:

Email:

**I have received consent to refer**    Yes    No

Please only include OHIP of referred persons:

**I am referring:**    Person with Dementia    Care Partner    Both

**Care Partner OHIP#:**

**Please contact:**    Person with Dementia    Care Partner    Both

**Person w/Dementia OHIP#:**

**Reason for Referral**

Recently Diagnosed	Emotional Support	Information/Education	Finding Community Supports
Living Arrangement/ Transition Support	Changes in Behaviour	Safety Concerns	Staying Socially/Physically Engaged
Other/Specific Program, please specify:			

**Additional Notes:**

**Known Risks:**    Yes    No    If yes, please select all that apply:

Family dynamics	Infectious diseases	Infestation/Squalor	Pets	Physical Environment
Recent hospitalizations	Responsive behaviours	Smoking	Weapons	Other:

**Please send supplemental documentation as appropriate.**