First Link Premier lien

Alzheimer Society PEEL

FIRST LINK® REFERRAL FORM- ALZHEIMER SOCIETY PEEL

CONSENT TO CONTACT: ☐ Yes ☐ No **DATE:** _____

PERSON DIAGNOSED INFORMATION: *Formal diagnosis not required*

Person Diagnosed Name: _____ **Date of Birth:** _____
mm/dd/yyyy

Person Diagnosed Resides in: ☐ Mississauga ☐ Brampton/Bolton/Caledon ☐ Other: _____

Address/Postal Code/Phone: _____

Diagnosis: _____ Coordinated Care Plan ☐
Health Links ☐

CONTACT PERSON INFORMATION (If different from above)

Contact Person's Name: _____

Relationship to Person Diagnosed:
☐ Spouse/Partner ☐ Son ☐ Daughter ☐ Community Support ☐ Other: _____

Phone/ Email: _____ **May leave a message:** ☐ Yes ☐ No

Services Needed: (check all that apply)

- ☐ Counselling
- ☐ Adult Day Program (Info/Tour)
- ☐ Respite (Nora's House)
- ☐ Education
- ☐ Behavioural Supports Ontario (You will be contacted)

Referral Checklist: (check all that apply)

- ☐ Emotional Support
- ☐ Community Support Navigation
- ☐ Behavioural Changes
- ☐ Safety Concerns
- ☐ Other:_____

REFERRAL MADE BY (YOUR INFORMATION)

Name: _____ **Phone:** _____

Location: _____

Email: _____

Central West & Mississauga Halton
PLEASE FORWARD THE REFERRAL TO:
first.link@alzheimerpeel.com
Phone: 289-632-2273 | **Fax: 905-507-1991**

Submit
Print
Save

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