Société Alzheimer Society

First Link® Premier lien®

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Tel: 705-495-4342 Fax: 705-495-0329
alzheimersudbury.ca

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

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

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

Please only include OHIP of referred persons:

Care Partner OHIP#:

Person w/Dementia OHIP#:

Reason for Referral

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

❑ Cognitive Assessment
❑ Initial screen
❑ Reassessment (previous screen date):

Name of physician for results (name/phone):

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.

Submit Referral