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:
l 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	Cognitive Assessment

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: 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: