

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 am referring:

Person with Dementia

Care Partner

Both

Please contact:

Person with Dementia

Care Partner

Both

I have received consent to refer

Yes

No

Reason for Referral

Cognitive Assessment

Emotional Support

Information/Education

Finding Community Supports

Recently Diagnosed

Changes in Behaviour

Safety Concerns

Staying Socially/Physically Engaged

Living Arrangement/Transition Support

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.