**Alzheimer Society**
SIMCOE COUNTY

First Link® Premier lien®

20 Anne Street South, P.O. Box 1414, Barrie, ON L4M 5R4
Tel: 705-722-1066 Fax: 705-722-9392
alzheimer.ca/en/simcoecounty

**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):

Telephone Number:

Address:

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):

Telephone Number:

Address: Same as above Other, please specify:

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:

**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.**