Alzheimer Society
SIMCOE COUNTY
First Link® Premier lien™
20 Anne Street South, PO Box 1414, Barrie, ON L4M 5R4
Tel: 705 722 1066 Fax: 705 722 9392
Alzheimer.ca/en/simcoecounty

-REFERRAL FORM-

***Date of Referral:**

***Person with Dementia Name (probable or diagnosed):**
(First name, Last name)

Diagnosis:
(please specify)

Date of Diagnosis:
Under Investigation: ☐

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:

****If Care Partner is the person being referred or is the primary contact, please fill out this section****

***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:
E-mail:

***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 person(s):

Care Partner OHIP:

Person w/dementia OHIP:

***Programs & Services Referring to:**

Navigation/Support
- ☐ First Link® Care Navigation (newly diagnosed)
- ☐ Supportive Counselling
- ☐ Care Partner Support Group
- ☐ Enhancing Care Program (CARERS/TEACH) skills based group therapy

Self-Management/Education Programs
- ☐ Person Living w/Dementia Learning Series
- ☐ Care Partner Learning Series

Social/Recreation
- ☐ Minds in Motion®
- ☐ In-Home Recreation

☐ **Information Package Only**

***Primary Reason(s) for referral:**

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 ensure to provide **full name, address and phone number** for the primary contact.