Alzheimer Society
PETERBOROUGH, KAWARTHA LAKES, NORTHUMBERLAND & HALIBURTON

First Link® Premier lien®

18-360 George St. North Peterborough, ON K9H 7E7
705-748-5131 Fax: 705-748-6174
alzheimerjourney.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**

❑ 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.**