

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:

I 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	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.