

Date of Referral:

www.alzheimer.ca/algoma | info@alzheimeralgoma.org

Person with Dementia Name (probable or diagnosed):

(First name, Last name)

Diagnosis & Date of Diagnosis (if known):

Specify
here:

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:

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.