Alzheimer Society
KENORA/RAINY RIVER DISTRICTS

FIRST LINK® REFERRAL FORM

Complete this form and print, then fax to: 807-468-9013

Date of referral: _____

Consent to share personal information attained? ☐ **Yes** ☐ **NO**

Please contact: ☐ **Caregiver** ☐ **Person with dementia** ☐ **Both**
Language: ☐ **English** ☐ **French** ☐ **Other:** _____
May we leave a message? ☐**Yes** ☐**No**

Please refer the following individual(s):

Referral source information
Name: _____Title: _____
Organization: _____
Address: _____City: _____
*Postal Code: _____Phone: _____Fax: _____
(* **Your postal code is required**)
Email: _____

Person with dementia
Name: _____ Male ☐ Female ☐
Address: _____Date of birth: (mm/dd/yyyy) _____
City: _____Postal Code: _____ Diagnosed by: _____
Daytime phone: _____Date of diagnosis: _____
Living alone? ☐ Yes ☐ No
Diagnosis:_____

Caregiver
Name: _____ Male ☐ Female ☐
Address(If different) _____ Relationship to person with dementia:
City: _____ Postal Code: _____ Spouse ☐ Child ☐
Daytime phone: _____ Other phone _____

Please contact:
ASAP ☐
2-4 weeks ☐

Client needs:
Support \ Counselling ☐ Community Resources Info ☐
Education ☐ Other _____

The Alzheimer Society adheres to professional standards for confidentiality for personal *information in accordance with the Freedom of Information and Protection of Privacy Act.*