

**First Link Referral Form**

Fax: 613-523-8522  
Phone: 613-523-4004  
Email: info@asorc.org



Date: \_\_\_\_\_

**Referral Source Information:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Organization/Agency: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City Postal Code

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_ Email: \_\_\_\_\_

**Client Information (Person with Dementia):**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Living Alone:  Yes  No  Male  Female

Diagnosis: \_\_\_\_\_ Diagnosis Date: \_\_\_\_\_  
(Alzheimer's disease, Vascular, FTD)

Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Contact Person Information (\*If different than above)**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City Postal Code

Relationship to PWD:  Spouse  Child  Other: \_\_\_\_\_  
Please specify

Male  Female Year of Birth \_\_\_\_\_

Language:  English  French  Other \_\_\_\_\_

**Period of wait time preferred:**

Adjusting to diagnosis – Minimum of three weeks  Requesting support ASAP

May leave message?  Yes  No

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_

A First Link™ Intake Coordinator will be contacting the above named contact person to discuss the First Link™ community of learning, services and support.