First Link Premier lien

Referral Form
Alzheimer Society of Ottawa and Renfrew County
In collaboration with the Champlain Dementia Network
Phone: 613-523-4004 Fax: 613-523-8522

Date: _____

Your information

Name: _____ Title: _____

Type of Practice / Community Partner:

❑ Family Health Team ❑ Community Health Centre ❑ Private Practice ❑ Other_____

❑ CCAC ❑ GPCSO ❑ ROMHC ❑ TOH: Neuro Psych ❑ MDC ❑ GAU Civic

❑ GAOT East ❑ GAOT West ❑ GADH Civic ❑ GADH QCH ❑ GADH EBHC

Discipline / Role: ❑ Family Physician/GP ❑ Allied Health ❑ Specialist

Address:_____
Street City Postal Code

Phone#:_____ Fax#:_____ Email:_____

Patient Information

Name: _____ DOB: _____

Address: _____ Phone #:_____

❑ Male ❑ Female ❑ English ❑ French ❑ other: _____

Living Alone: Yes / No

Diagnosis: _____ DX date: _____

Diagnosing Physician:_____ Family Physician:_____

Contact Person Information

Name: _____ Phone #: _____

Address: _____
Street City Postal Code

Relationship to PWD ❑ spouse ❑ child other_____

❑ English ❑ French other_____

Period of wait time preferred:

❑ Adjusting to diagnosis – Minimum of three weeks ❑ Requesting support ASAP

Additional Comments:_____