Alzheimer Society York Region

First Link® Premier lien

Proud members of the EYRND Ontario Health Team

Date of Referral:		
Person with Dementia (probable or diagnosed) Name: (First Name, Last Name)		
Diagnosis: (if known)	☐ Under Investigation	Date of diagnosis: (if known)
Date of birth: (mm/dd/yy)	Address: (Street address, City, Postal code)	
OHIP#:		
Phone:	Email address:	
Preferred Language: ☐English ☐French ☐Other:		

Care Partner Name: (First Name, Last Name)		Relationship to above:
Date of birth: (mm/dd/yy)	Address: (If different from above)	
Primary phone:		
Secondary phone:	Email address:	
Preferred language: ☐ English ☐ French ☐ Other:		

Please contact: ☐ Person with Dementia ☐ Care Partner ☐ Other:	
Preferred contact method: ☐ Phone ☐ E-mail ☐ Other:	
Preferred contact time: (if known)	**Can a message be left?:** ☐ Yes ☐ No

Referral Source Name & Agency:	Address:	
	Phone:	Fax:
	Email:	

Additional notes:

Completed forms can be sent to the Alzheimer Society of York Region by FAX to 905-726-1917

Please send supplemental documentation as appropriate.

If you have any questions or concerns, please contact our First Link Coordinator, Sara MacLean, at 905-726-3477 ext. 235 or smaclean@alzheimer-york.com.