

Referral Form



Ask individual for permission to refer them to the Alzheimer Society of Calgary

Forward referral information to: **403-269-8836 (fax) or info@alzheimercalgary.ca (email)**

Referral Source _____ **Date** _____

NAME

ORGANIZATION

☐ Family Clinic ☐ Home Care ☐ Seniors Health Clinic ☐ PCN (specify) _____
☐ Dementia Advice Line ☐ Acute Care ☐ Other (specify) _____

DESIGNATION

☐ Family Physician ☐ Geriatrician ☐ Psych Allied Health ☐ Nurse ☐ Nurse Practitioner ☐ Social Worker ☐ Other _____

PHONE

FAX

EMAIL

ADDRESS

CITY/TOWN

POSTAL CODE

Who should we contact? _____

☐ PLWD ☐ Caregiver **CONTACT** ☐ Urgent ☐ Not Urgent **OKAY TO LEAVE MESSAGE?** ☐ Yes ☐ No

Person Living with Dementia (PLWD) _____

FIRST NAME & LAST NAME:

IDENTIFIES AS

☐ Male ☐ Female ☐ Transgender ☐ Non Binary ☐ Prefer not to disclose

CITY/TOWN

PROVINCE

POSTAL CODE

PHONE

DIAGNOSIS (EX: AD, VAD)

DIAGNOSIS DATE

Caregiver _____

FIRST NAME & LAST NAME:

IDENTIFIES AS:

☐ Male ☐ Female ☐ Transgender ☐ Non Binary ☐ Prefer not to disclose

CITY/TOWN

PROVINCE

POSTAL CODE

RELATIONSHIP TO PERSON WITH DEMENTIA

EMAIL

PRIMARY PHONE NUMBER

SECONDARY PHONE NUMBER

Comments _____

CONSENT DISCUSSED

SIGNATURE OF CONSENT (OPTIONAL)

☐ Yes ☐ No

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To download a fillable PDF form, go to: <https://www.alzheimercalgary.ca>
Please call (403) 290-0110 or Toll-Free: 1-877-569-HELP (4357) for more information.