

Referral Form

Ask individual for permission to refer them to the Alzheimer 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)

NAME

IDENTIFIES AS:

- Male
 Female
 Transgender
 Non Binary
 Prefer not to disclose

CITY/TOWN

PROVINCE

DIAGNOSIS (EX: AD, VAD)

DIAGNOSIS DATE

Caregiver

NAME:

IDENTIFIES AS:

- Male
 Female
 Transgender
 Non Binary
 Prefer not to disclose

CITY/TOWN

PROVINCE

POSTAL CODE

RELATIONSHIP TO PERSON WITH DEMENTIA

EMAIL

HOME PHONE

CELL PHONE

BUS. PHONE

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.