



Alzheimer Society of Calgary
 Tel: 1-877-569-4357; 403-290-0110
 Fax: 403-269-8836
 info@alzheimercalgary.ca
 Website: www.alzheimercalgary.ca

Working together to link individuals and families affected by Alzheimer's disease or other dementias to a community of learning, services, and support.	Please refer: _____ to First Link®. Date of Referral: _____ Approximate date of diagnosis: _____ Diagnosis (e.g. AD, VaD): _____ Contact Person: _____ <small>(if different from above)</small> Relationship to the person with dementia: _____ Phone: _____ May leave message?: <input type="checkbox"/> Yes <input type="checkbox"/> No Referred by: _____ Referring Clinic/PCN/Agency : _____ Address: _____ _____ Postal Code: _____ Phone: _____ email: _____
Comments on the situation (other medical concerns; family situation; etc): 	

Statement of Consent/Signature

I _____ (name) of _____ (city/town) authorize the above information to be shared with the Alzheimer Society of Calgary.

PWD or Caregiver Signature: _____ Witness: _____

In lieu of written consent, was verbal consent received: Yes or No Staff Initials: _____

The information contained in this transmission is confidential and intended only for the use of the individual or entity to whom it is addressed. If you are not the intended recipient, you are hereby notified that any distribution, copying, disclosure and use of, or reliance on, the comments of this transmission is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone and permanently destroy the original message and all copies.