Alzheimer Society TORONTO

First Link® Premier lien

PLEASE NOTE: This program is for people living with dementia and/or caregivers who reside in Toronto ('M' postal code)

Person with Dementia (PWD):

Name*: _____

Date of Birth: _____

Diagnosis*: _____

Preferred Language: _____

Phone Number: _____

PWD resides:

☐ Alone ☐With a Caregiver ☐ In a residential facility

Client OHIP Number: _____

Caregiver / Contact Person:

Name*: _____

Date of Birth: _____

Relationship to PWD: _____

Preferred Language: _____

Phone number*: _____

Email: _____

Address*: _____

Caregiver OHIP Number: _____

Please contact*: ☐ Person with Dementia ☐ Caregiver

To be contacted: ☐ Urgent ☐ 2-5 days ☐ 1-2 weeks

If urgent, why: _____

_____

Preferred method of contact: ☐ Phone ☐ Email

Okay to leave voice message: ☐ Yes ☐ No

Consent to contact provided by client*: ☐ Yes ☐ No

Services Required:

If **Social Work** is required, please check all that apply:

☐ Just Diagnosed ☐ Brain Health (e.g. Diet/Exercise)

☐ Advanced Care Planning

☐ Counselling ☐ Behavioural Changes

☐ Caregiver Stress / Emotional Support

☐ LTC Planning / Transitions

☐ Support someone who lacks insight

What other service(s) is/are required?

☐ Support Group ☐ Music Project

☐ Education / Workshops

☐ MedicAlert Safely Home Bracelet

☐ Caregiver Project ☐ Active Living

If **System Navigation** is required, please check all that apply:

☐ LTC Planning / Transition ☐ Finances

☐ Advanced Care Planning ☐ Housing Concerns

☐ Accessing / connecting to health and community support services ☐ Driving Concerns

☐ Meaningful Activities / Staying Engaged

☐ Safety Concerns (wandering, hoarding, cooking)

Referral Source Information:

Name*: _____

Organization*: _____

Phone*: _____ | Email*: _____

*** Required**

Fax form to: 416-322-6656

For information about the status of your referral, or for any questions, please contact:

Alzheimer Society of Toronto | Tel: 416-322-6560 | | Email: intake@alz.to