

Referring Source:

Name:
 Agency/Organization:
 Telephone Number: "Backline" (unlisted) Number:
 Fax Number: E-mail Address:
 Address:
 Signature: Date:
If you are a physician:
 Billing Number and Specialty:

Family Caregiver Information:

Caregiver's Name: DOB (Y/M/D):
 Male Female
 Health Card Number: Version Code:
 Address:
 Telephone Number:
 Is the caregiver fluent in English? Yes No *If "No", language(s) spoken:*
 Family Physician's Name (if different from above):
 Telephone Number: "Backline" (unlisted) Number:
 Fax Number: E-mail Address:
 Address:

Background Information - To your knowledge:

Does the caregiver provide daily, direct, hands-on care for the person with dementia? Yes No
 Does the caregiver live with the person with dementia? Yes No
 What is the relationship of the caregiver to the person with dementia?
 Spouse Child Sibling Other
 Has an assessment been done and a diagnosis of dementia been given? Yes No
 • *If "No", additional comprehensive services are available in the Centre, including full assessment and treatment. For your convenience, please see the attached referral form to our Outpatient Geriatric Psychiatry Program.*

**Please fax completed form to 416-586-3231 or email to
reitmaninquiries@mtsinai.on.ca**