



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

Date:		
Person with Dementia:	Caregiver / Contact Person:	
Name:	Name:	
Date of Birth:	Relationship to person with dementia:	
Diagnosis:	Preferred Language:	
Preferred Language:	Phone Number:	
Phone Number:	Email Address:	
Email Address:	Mailing Address:	
Person with dementia resides:		
Alone With a caregiver In a residential facility		
Please Contact: ☐ Person with Dementia ☐ Caregiver / Contact Person Preferred method of contact: ☐ Phone ☐ Email	on 🗆 Both	
To be contacted: ☐ As soon as possible ☐ Other:		
The contact person has given consent to be contacted by the Alzheimer Society of Toronto: Yes No Is it okay if we leave a voice message: Yes No		
Services Required: Counselling Support Group Information Package Services in the Community (ie. ADP) iPod Project Education MedicAlert Safely Home Caregiver Project Other: Additional Information:		
Referral Source Information:		
Name: Tit	tle/Position:	
Organization:		
Phone: Fa		
E-mail:		
Follow-up Preference:		

For more information about referring a client/patient please contact:

Shrid Dhungel, First Link Coordinator
Alzheimer Society of Toronto

Tel: 416-640-6316 | Fax: 416-322-6656 | Email: <u>SDhungel@alz.to</u>





FOR INTERNAL USE ONLY

Completed By:	
☐ Explained and offered AST services	Contact / Attempts:
☐ Information package was sent to client	/ / at
☐ Client prefers to contact AST as needed	
☐ Counsellor was unable to reach client	/at
☐ Client was referred to local chapter	/at
☐ Counsellor will call client again (specify when)	
☐ Counsellor will meet with client	Comments:
☐ Other:	