



Date: \_\_\_\_\_

**\*Required Fields**

Consent to share personal information attained?  Yes  No

**Referral Source Information:**

*Please Print Clearly*

\*Your Name: \_\_\_\_\_ Department: \_\_\_\_\_  
\* Organization: \_\_\_\_\_  
\* Phone: \_\_\_\_\_  
\* Email: \_\_\_\_\_  
Please indicate who should be contacted (As below):  Caregiver  Person with Dementia  Both

**Caregiver:**

Region: Ottawa    Renfrew County    Other  
\* Name: \_\_\_\_\_ \* Gender: M  F  N  T   
\* Address: \_\_\_\_\_ Date of Birth: (mm/dd/yyyy) \_\_\_\_\_  
City: \_\_\_\_\_ \* Postal Code: \_\_\_\_\_ \* Relationship to Person with Dementia:  
\* Daytime Phone: \_\_\_\_\_ Spouse  Child   
Secondary Phone: \_\_\_\_\_ Other: \_\_\_\_\_  
\* Email: \_\_\_\_\_ \* Health Card Number: \_\_\_\_\_  
\* Language:  English  French  Other: \_\_\_\_\_ Is it safe to leave a message?  Yes  No

**Primary Reason for Referral**

Education     Peer Support     Support/Counselling     Community Resources

**Person with Dementia:**

\* Name: \_\_\_\_\_ \* Gender: M  F  N  T   
\* Address: \_\_\_\_\_ Date of Birth: (mm/dd/yyyy) \_\_\_\_\_  
City: \_\_\_\_\_ \* Postal Code: \_\_\_\_\_ Diagnosed By: \_\_\_\_\_  
\* Daytime Phone: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_

**Comments:**

For more information call:

Ottawa: 613-523-4004  
Renfrew County: 888-411-2067

Thank you for your referral