Today's Date: _____

FAX form to (613) 345-3186

Alzheimer Society of Leeds-Grenville Intake Form

REFERRAL INFORMATION

Name (PWD): Phone Number:

Street Address: City: Postal Code:

Date of Birth (yy/mm/dd): Health Card #

Caregiver Name: Relationship: ☐ Spouse ☐ Child ☐ Other

Caregiver Phone Number: Email:

Date of Diagnosis: _____

☐ Not yet diagnosed

☐ Alzheimer Disease

☐ Frontotemporal dementia

☐ Mixed dementia (&)

☐ Vascular dementia

☐ Lewy-body dementia

☐ Parkinson's dementia

☐ Diabetes

☐ MCI

☐ Other (specify):

-

-

-

-

-

Comments:

REFERRAL SOURCE INFORMATION

Name of Referring Care Provider: Phone:

Email: Fax: