



Client Referral Form

1. Ask for permission to forward individual's name to the Alzheimer Society
2. Send completed forms to : Alzheimer Society Timmins- Porcupine

70 Cedar St South, Timmins, ON P4N 2G6

Fax: 705-360-4492 Phone: 705-268-4554 Toll Free: 1-844-288-4554

3. Please Support: ☐ Person with dementia ☐ Care Partner
☐ Both

Person with dementia:

Name _____
Address _____
City _____
Province _____ Postal Code _____
Phone # _____

Gender _____
Date of Birth _____
Family Doctor _____
OHIP _____
Diagnostic _____

Care Partner:

Name _____
Address _____
City _____
Province _____ Postal Code _____
Home Phone # _____
Business Phone # _____
Cell _____
E-mail _____

Relationship to person with dementia _____
Preferred Contact Method: _____
Preferred Contact Time: _____

Referral Info:

Referred by _____
Address _____
City _____
Province _____ Postal Code _____

Agency _____
Discipline Role _____
Business Phone _____
E-mail _____

Please Contact:

- ☐ Urgent (1 Week)
☐ Please contact in 2-4 weeks

Client's needs:

- ☐ Support/Counselling
☐ Education
☐ Other _____

Comments:

