

**FIRST LINK® REFERRAL FORM- ALZHEIMER SOCIETY PEEL**

**CONSENT TO CONTACT:** ☐ Yes ☐ No

**DATE:** \_\_\_\_\_

**PERSON DIAGNOSED INFORMATION:** *Formal diagnosis not required*

**Person Diagnosed Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
mm/dd/yyyy

**Person Diagnosed Resides in:** ☐ Mississauga ☐ Brampton/Bolton/Caledon ☐ Other: \_\_\_\_\_

**Address/Postal Code/Phone:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **Coordinated Care Plan** ☐  
**Health Links** ☐

**CONTACT PERSON INFORMATION** (If different from above)

**Contact Person's Name:** \_\_\_\_\_

**Relationship to Person Diagnosed:**

☐ Spouse/Partner ☐ Son ☐ Daughter ☐ Community Support ☐ Other: \_\_\_\_\_

**Phone/ Email:** \_\_\_\_\_ **May leave a message:** ☐ Yes ☐ No

**Services Needed:** (check all that apply)

- ☐ Counselling
- ☐ Adult Day Program (Info/Tour)
- ☐ Respite (Nora's House)
- ☐ Education
- ☐ Behavioural Supports Ontario (You will be contacted)

**Referral Checklist:** (check all that apply)

- ☐ Emotional Support
- ☐ Community Support Navigation
- ☐ Behavioural Changes
- ☐ Safety Concerns
- ☐ Other: \_\_\_\_\_

**REFERRAL MADE BY (YOUR INFORMATION)**

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Email:** \_\_\_\_\_

Central West & Mississauga Halton  
PLEASE FORWARD THE REFERRAL TO:  
**first.link@alzheimerpeel.com**  
Phone: 289-632-2273 | Fax: 905-507-1991