Carewest
INNOVATIVE HEALTH CARE

Living with Dementia Referral

IMPORTANT: Missing or incomplete information will delay processing. Please see list on 2nd page for required information.

Date: _____ YYYY/Mon/DD

Carepartner Information

Last Name: _____ First Name: _____

Gender: M ☐ F ☐ DOB: _____ PHN: _____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Alt Phone: _____

Contact Person: _____ Relationship: _____

Phone: _____

Referring Source: _____

Phone:_____ Fax: _____

Name of Family Physician (*if different from referring source)* _____

Phone: _____ Fax: _____

Home Care Coordinator: _____

Please explain the reasons for carepartner referral to Living with Dementia program

_____
_____
_____
_____
_____

Are there other family members/supports who would be interested in attending?

_____

Revised December 2018

□ ESL Degree of fluency in English: _____

Person with Dementia

Last Name: _____ First Name: _____

Gender: M □ F □ DOB: _____ PHN: _____

Address: (if different from above)

_____

City: _____ Postal Code: _____

Home Phone: _____ Alt Phone: _____

Contact Person: _____ Relationship: _____

Phone: _____

Dementia diagnosis (including type/year):

_____
_____
_____

Please describe any behaviors that should be noted:

_____
_____
_____
_____
_____

Please include the following:

Physicians Report
Cognitive assessments/results
Geriatric Assessment

- Caregiver and person with Dementia must be able to attend regularly and participate in group activities in a full day program

Please fax completed form and additional information to Carewest Day Hospital. Fax: (403) 258-7681

For questions or concerns, please call (403) 640-6484

Revised December 2018