

## First Link® Referral Program

The First Link® Referral Program provides an opportunity for health care providers to refer a person with cognitive changes or a diagnosis of dementia and those who support them to the Alzheimer Society for information, support and education. ***Please fill out and fax completed referrals to the Alzheimer Society Provincial Office: 1-833-638-0760***

<p><b>Select one (1) preferred regional office:</b></p> <p><input type="checkbox"/> Interlake/Eastern Office – Selkirk</p> <p><input type="checkbox"/> North Central Office – Portage la Prairie</p> <p><input type="checkbox"/> Parkland Office – Dauphin</p>	<p><input type="checkbox"/> Provincial Office – Winnipeg</p> <p><input type="checkbox"/> South Central Office – Winkler</p> <p><input type="checkbox"/> South Eastman Office – Steinbach</p> <p><input type="checkbox"/> Westman Office – Brandon</p>
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<p><b>Referral date:</b> _____</p>	<p><b>Consent received:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Please contact:</b> <input type="checkbox"/> Person with dementia <input type="checkbox"/> Caregiver</p>	

<p><b>Person with Dementia</b></p> <p>Name: _____</p> <p><input type="checkbox"/> Person with cognitive changes</p> <p><input type="checkbox"/> Diagnosed with dementia</p> <p>Person resides:</p> <p><input type="checkbox"/> Alone <input type="checkbox"/> With a caregiver <input type="checkbox"/> In a residential facility</p> <p>Phone: _____</p>	<p><b>Care Partner</b></p> <p>Name: _____</p> <p><input type="checkbox"/> Spouse/partner <input type="checkbox"/> Adult Child</p> <p><input type="checkbox"/> Other (please specify) _____</p> <p>Home Phone: _____</p> <p>Cell Phone: _____</p> <p>Email: _____</p> <p>Home Address: _____</p> <p>City/Town: _____</p> <p>Postal Code: _____</p> <p>May leave voice message? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<b>Referral source (Required):</b>	
Name: _____	Clinic/Agency: _____
Phone: _____	Fax: _____
Email: _____	

### Reason for Referral:

<p><b>Follow-up Request: Please select one (1)</b></p> <p>Please provide a report in: <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 months <input type="checkbox"/> no report requested</p>
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The Alzheimer Society is committed to protecting the privacy and personal information of the people we provide services to. The information provided on this form will only be used to inform persons with dementia and their families about dementia and the programs/services that may be helpful to them.

For more information, call **1-800-378-6699** or email [support@alzheimer.mb.ca](mailto:support@alzheimer.mb.ca)