Société Alzheimer Society
KINGSTON, FRONTENAC, LENNOX & ADDINGTON

Language:
- ☐ English
- ☐ French
- ☐ Other

Referral Form	
Patient Name:	Phone #:
Street Address:	City:
Caregiver Name:	
Relationship to Patient:	Caregiver Phone #
Date of Diagnosis:	

Diagnosis:

Alzheimer's Disease Vascular Dementia Frontotemporal Dementia
Lewy-Body Dementia Mixed Dementia MCI
Korsakoff's Syndrome Dementia due to head trauma

Dementia due to other illness (i.e. Parkinson's, HIV) _____

Other (specify): _____

Comments:

Referral Source Information	
Name of Referring Care Provider:	
Phone:	Fax #:

Type of Practice:

Independent physician Family Health Team (specify which team) _____
Private PCC Geriatric Outreach S.M.O.L Community Agency
Other _____

Discipline

General Practitioner Allied Health CCAC Private Other _____
Specialist _____

Today's Date _____

Fax Form to (613) 544-6320