Text

Description automatically generated with medium confidence

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Enhancing Care Program Referral Form**  **Fax completed referral form to Lauren Casagrande**  **Fax (519) 915 0202, Phone (519) 974 2220 x251**  **Referring Source**   |  |  | | --- | --- | | Full Name: | Agency/Organization: | | Telephone Number: | Fax Number: | | Email Address: | Date: | | |
| **Program: □ CARERS □ TEACH** | |
| **Family Care Partner Information** | |
| Given name (Care partner): | Surname (Care partner): |
| Telephone: Home number | Cell number: |
| Email Address: | |
| Address: | Relationship of the care partner to the person living with dementia?  □ Spouse/Partner □ Child □ Sibling  □ Other (specify): |
| City, Province, Postal Code: |

**Additional Information**

|  |  |
| --- | --- |
| Does the care partner provide daily, direct, hands-on care for the person living with dementia?  □ Yes □ No | Does the care partner live with the person living with dementia?  □ Yes □ No |
| Has a diagnosis of dementia been given? □ Yes □ No | |
| Additional Information: | |