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| **Enhancing Care Program Referral Form****Fax completed referral form to Lauren Casagrande****Fax (519) 915 0202, Phone (519) 974 2220 x251****Referring Source**

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| 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**

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| 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:  |