



Connecting Minds Through Compassionate Hearts
Social Engagement Programs for Persons Living with Early Dementia

Referral Form

Date: _____

1. Referring Person/Organization

Name: _____ Organization: _____

Phone Number: _____ Email Address: _____

2. Participant Information

Full Name: _____ Phone number: _____

Date of Birth: _____ Age: _____

Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say Primary Language: _____

Address: _____ Postal Code: _____

3. Diagnosis

☐ Alzheimer's Disease ☐ Vascular Dementia ☐ Lewy Body Dementia ☐ Frontotemporal Dementia

☐ Mild Cognitive Impairment ☐ Mixed Dementia ☐ Other (please specify) _____

Date of Diagnosis (if known): _____

4. Emergency Contact and/or support person

Name: _____ Relationship: _____

Phone Number: _____

6. Additional Notes

(Include any relevant information about the person's preferences, routines, or communication style.) _____

Have you obtained consent for us to call this client or their support person: YES or NO

Best Time to call: _____ Who do we speak with: _____

Client criteria for early-stage dementia

Evidence of modest cognitive decline in one or more domains (e.g., memory, attention, executive function).

Preserved independence in daily activities, though greater effort or compensatory strategies may be required.

Cognitive deficits are not due to delirium or another mental disorder

Kindly send to Laurie De Croos ldecroos@pghpcs.ca (250) 563 2551

Thank you for your referral.