Société Alzheimer Society
NOVA SCOTIA

First Link® Premier lien™

Fill in ONE or BOTH boxes below

Date: *2014/07/14*

1. Please refer the following **friend/family caregiver** to the ASNS First Link® Program

Friend/ family caregiver:

Name: _____ (the person we will call)

Relationship to PWD: _____

Daytime phone number: _____ May we leave a message? Y ☐ N ☐

Consent for ASNS to contact friend/family member: _____
Signature

Date: _____

AND/OR

2. Please refer the following **person with dementia*** to the ASNS First Link® Program
(Do NOT complete this section if you are referring a caregiver only)

Person with dementia:

Name: *Patient Beta Sample* (the person we will call)

Daytime phone number: *(902) 555-0248 work* May we leave a message? Y ☒ N ☐

Consent for ASNS to contact the person with dementia: _____
Signature of person with dementia or substitute decision maker

Date: *2014/07/14*

Comments/Special Instructions: ***Sed sagittis justo. Phasellus tincidunt neque velit, non interdum risus vestibulum nec. Sed iaculis enim eu neque rhoncus, vel dictum nisi molestie. Class aptent taciti sociosqu ad litora torquent per conubia nostra, per inceptos himenaeos. Aliquam placerat faucibus viverra. Donec lobortis quam leo, et mollis ipsum pellentesque ut. Vivamus orci quam, dignissim quis justo in, imperdiet adipiscing mi. Etiam gravida, orci a elementum porta, sapien erat bibendum purus, id pretium erat metus eget pu.***

Referred by (please print): *DR. BHARTI VERMA* Clinic: *Test Clinic 18*

Address: *123 Any St., Suite 147*
Halifax, NS
B1B 1B1

Phone Number: *(902) 555-5555*

Fax Number: *(902) 555-5732*

Forward referral information by fax: (902) 422-7971

We attempt to call clients within 3 weeks of referral. Contact sooner? Y ☐ N ☒

Request phone confirmation that referral was received? Y ☒ N ☐

Request follow-up report? Y ☐ N ☒

Fax ☐ Mail ☐

* This includes Alzheimer's disease, any other dementia and cognitive impairment.