CARER

GERIATRIC PSYCHIATRY COMMUNITY SERVICES OF OTTAWA

DATE OF REFERRAL:

Care Partners (Caregiver) Last Name:		Given Name:		Health Card	Code
Address		City/Province		Postal Code	
Telephone No. Email:	Date of Birth (day/mo/yr)	Marital Status	Language	Gender	
Relationship to the person living with dementia (spouse, child or other):			☐		

Family Physician:	Telephone No.

Referral Source:	Telephone No.	**Fax No.**
Address	City/Province	Postal Code
	Client Aware of Referral? ☐ Yes	☐ No

Reason for Referral: **ENHANCING CARE FOR ONTARIO CARE PARTNERS**
Group program delivering therapeutic skills training intervention to Care Partners (Caregivers).

Does Care Partner (Caregiver) provide daily, direct care for person with dementia? ☐ **Yes** ☐ **No**

Does Care Partner (Caregiver) live with person with dementia? ☐ **Yes** ☐ **No**

Has a diagnosis of dementia been made? ☐ **Yes** ☐ **No**

if yes what is the diagnosis _____

Does Care Partner (Caregiver) have access to computer, web cam, microphone and internet at home? ☐ **Yes** ☐ **No**

MAIL OR FAX TO

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