



Windsor Essex System Navigator Referral Form

Name:
DOB (dd/mm/yyyy):
HCN:
Other ID:

Reason for Referral:	Transitional Support	LTCH Referral (Lead Team)	Community Referral
Previous Referral Made:	YES	NO	
Responsive Behaviour/Personal Expression Overview			
Collecting/Rummaging	Other		
Connection Seeking	Physically Responsive Behaviour		
Distressed Behaviour (Agitated)	Refusing Care or Treatment		
Exploring/Searching (Exit Seeking, Pacing)	Sexually Responsive Behaviour		
Expression of Self-Harm (Suicidal Ideation)	Suspicious or Paranoid Behaviour		
Indiscriminate Ingestion of Foreign Substances	Verbally Responsive Behaviour		
Low Mood (contributing to health consequences)			
Referral Source Information			
CONSENT OBTAINED (Consent is required):	YES	NO	
Name & Title:	Date of Referral:		
Organization:	Phone:		
Address:	Fax:		
Client Information (if different than above)			
Address:	Phone:		
Medical Information			
Diagnosis:			
Family Physician:			
Has delirium been ruled out?	YES	NO	
Is Client acutely ill?	YES	NO	
Recent Urinalysis Completed YES , results:	Recent Lab Work Completed YES , results:		
NO , reason for not completing:	NO , reason for not completing:		
Behaviour Assessment Checklist completed and attached? YES , date: NO , reason for not completing:			
First Contact Information			
Name:	Phone:		
Relationship to Client:			
POA Status & Name of POA:			
Comments:			

Fax Completed Form to: Alzheimer Society FAX 226-216-5295 PHONE 519-355-4108 OR 519-890-4845

