CARERS / TEACH

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.	Date of Birth (day/mo/yr)	Marital Status	Language	Gender
Email:				
Relationship to the person living with dementia (spouse, child or other):				
Referral Source	Telephone No.			**Fax No.**

Availability

- ☐ In person group
- ☐ Day
- ☐ Virtual Group
- ☐ Evening

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

75 Bruyère St, Suite 127 Y, Ottawa, Ontario, K1N 5C7
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