The Dementia Society

REQUEST FOR SERVICE

First Name: _____ **Address:** _____

Last Name: _____ **Postal Code:** _____

How do you identify yourself?

☐ **Professional Referring a Client** *(See "If a professional referral: please fill out"):*

☐ **Caregiver of a Person With Dementia** *(Please Include Caregiver Health Card#):*

☐ **Person With Dementia:** *(Please Include Health Card#):*

☐ **Other** *(Please explain):*

How can we help you?

Please give us some information about your situation and what type of support and/or service you would like for yourself or someone else. Our support service staff will contact you or the person you have referred as soon as possible.

How can we contact you or the person you are referring?

Primary Telephone Number:

Secondary Telephone Number:

E-mail address:

Is it safe to leave a message? Yes

If a professional referral: please fill out

First Name:

Last Name:

Organization:

Postal Code:

City:

Phone Number:

Email:

Please use this space to provide any other information you feel is relevant

What is the best time of day to call you?

☐ *Daytime*

☐ *Evening*

SUBMIT

Thank you for your referral!

Fax: 613-523-8522 // Phone: 613-523-4004 // Email: Info@asorc.org

Providing Dementia Support Services since 1980