

March of Dimes Canada (MODC) After Stroke Program Community Referral

Basic Information		
Please select one: This referral is for a <input type="checkbox"/> Stroke survivor <input type="checkbox"/> Caregiver		
Surname:	Given name:	Preferred name:
Address:		
City:		Postal code:
Phone number:	Email:	
Date of birth:	Preferred method of contact: <input type="checkbox"/> Telephone <input type="checkbox"/> Email	
Primary language:	Is a family member available to interpret? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Contact Information		
Is the primary contact the same as above? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if selected, please complete the section below.)</i>		
Primary contact name:	Relationship to participant:	
Phone number:	Email:	
Preferred method of contact: <input type="checkbox"/> Telephone <input type="checkbox"/> Email		
Is there an ideal time to reach the primary contact?		
Referral Source Information		
Date of referral:		
Type of referral: <input type="checkbox"/> Self-referral <input type="checkbox"/> Referral for someone else <i>(if selected, please complete the section below.)</i>		
Name:	Phone number:	
Organization/Clinic/Centre (if applicable):	Email:	
<input type="checkbox"/> By checking this box, I am confirming that the client above has provided verbal consent for this referral.		

Return form via secure fax to 1-844-906-2422 or via email to afterstroke@marchofdimes.ca
 A member of our team will be in touch with you within 1 to 3 business days of receiving this referral.
www.afterstroke.ca