MARCH OF DIMES CANADA LA MARCHE DES DIX SOUS DU CANADA

After Stroke

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

Basic Information

Please select one: This referral is for a ☐ Stroke survivor ☐ Caregiver

Surname:	**Given name:**	**Preferred name:**
Address:		
City:	**Postal code:**	**Date of Birth:**
Phone number:	**Email:**	

Preferred method of contact: ☐ Telephone ☐ Email

Primary language:	**Is a family member available to interpret?** ☐ Yes ☐ No

Communication Challenges Identified? ☐ Yes ☐ No

If yes, please describe:

Primary Contact Information

Is the primary contact the same as above? ☐ Yes ☐ No *(if selected, please complete the section below.)*

Primary contact name:	**Relationship to participant:**
Phone number:	**Email:**

Preferred method of contact: ☐ Telephone ☐ Email

Is there an ideal time to reach the primary contact?

Referral Source Information

☐ **By checking this box, I am confirming that the client above has provided verbal consent for this referral.**

Date of referral:

Type of referral: ☐ Self-referral ☐ Referral for someone else
(if selected, please complete the section below.)

Name:	**Phone number / email:**
Organization/Clinic/Centre (if applicable):	**Email:**

Have any other referrals been made for this stroke survivor? ☐ Yes ☐ No

Please provide any additional information relevant to 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.

For more information on After Stroke please refer to our website at **www.afterstroke.ca**