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

Basic Information

Select one: This referral is for a ☐ Stroke survivor ☐ Caregiver **What was the date of your stroke?**

First Name:	**Last Name:**	**Preferred name:**
Address:		
City:	**Postal code:**	**Date of Birth *(mm/dd/yyyy):***
Gender: ☐ Man ☐ Woman ☐ Unknown ☐ Non-binary ☐ Prefer not to disclose	**Phone number:**	**Email:**

Preferred method of contact: ☐ Telephone ☐ Email

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

Are there any Communication Challenges? ☐ 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.)*

Name of contact person:	**Relationship to participant *(e.g., parent, sibling, friend, other)*:**
Phone number:	**Email:**

Preferred method of contact: ☐ Telephone ☐ Email

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 of person making this referral:	**Phone number / email:**
Organization/Clinic/Centre (if applicable):	**Clinic Phone number/Email:**

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

If yes, please provide details:

Additional information that is relevant to the referral:

Return form via secure fax to 1-844-906-2422 or via email to afterstroke@marchofdimes.ca

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