MARCH OF DIMES CANADA
LA MARCHE DES DIX SOUS DU CANADA

After Stroke

March of Dimes Canada – After Stroke Program
Referral Form

Referral date (mm/dd/yyyy)**:**

Program Candidate (individual being referred to the program)		
Select one ☐ Stroke survivor ☐ Caregiver	**Date of birth** (mm/dd/yyyy)	
Date of stroke (mm/dd/yyyy)	**Hospital discharge date** (mm/dd/yyyy)	
First name:	**Last name:**	**Preferred name:**
Address:		
City:	**Prov.:**	**Postal code:**
Phone number:	**Email:**	**Preferred method of contact:** ☐ Phone ☐ Email
Select one ☐ Male ☐ Female ☐ Prefer not to disclose ☐ Other:		
Describe any communication challenges and/or needs:		
Primary language:	**If unable to communicate in English, is a support person available?** ☐ Yes ☐ No	

Primary Contact (if different from the Program Candidate)		
Name of contact person:	**Relationship to candidate:** (e.g., partner, sibling, parent, other)	
Phone number:	**Email:**	**Preferred method of contact:** ☐ Phone ☐ Email

Referral Source (if referring on behalf of the Program Candidate)		
Name of person making referral:		
Organization/Clinic/Hospital: (if applicable)		
Phone number:	**Email:**	**Preferred method of contact:** ☐ Phone ☐ Email

Additional relevant information: (e.g, any other referrals made, accommodations needed, etc.)

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