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

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