Primary Care Memory Clinic

Non-FHT

MEMORY CLINIC REFERRAL	Primary Care Memory Clinic Non-FHT Ph: 226-338-5942 Fax: 1-888-205-1491

Name of Referring Physician:		
Client's Name:	**Date of Birth:**	**Telephone:**
Address:	**City:**	**Postal Code:**
Health Card Number:		**VC (if applicable):**
Alternate Contact Person: **(REQUIRED)**	**Relationship:**	**Telephone:**

Client previously seen by Geriatrician or Memory Clinic	**☐ Yes**	**☐ No**
Client / family aware that referral has been made	**☐ Yes**	**☐ No**
Client has been informed that driving safety will be addressed	**☐ Yes**	**☐ No**

*****Referral may be declined if the client has not been informed*****

Reason for referral including relevant history (if this referral is considered <u>medically urgent,</u> please provide reasons):

URGENT Referral:	**☐ Yes**	**☐ No**
Delirium has been ruled out	**☐ Yes**	**☐ No**

<u>PLEASE INCLUDE</u> copies of all relevant documents :

- ☐ **Consult report / Specialist report**
- ☐ **Previous Cognitive Testing**
- ☐ **EKG**
- ☐ **CT Scan / MRI reports**
- ☐ **Current medication list**
- ☐ **Significant medical history**

<u>PLEASE INCLUDE</u> the following bloodwork if available:

- ☐ **CBC**
- ☐ **TSH**
- ☐ **Creatinine**
- ☐ **Electrolytes**
- ☐ **Glucose**
- ☐ **Vitamin B12**
- ☐ **Calcium**

Physician Name: _____ **OHIP Billing #:** _____

Physician Signature: _____ **Date:** _____