

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 medically urgent, please provide reasons):

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

PLEASE INCLUDE copies of all relevant documents :

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

PLEASE INCLUDE the following bloodwork if available:

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

Physician Name: _____ OHIP Billing #: _____

Physician Signature: _____ Date: _____