KW4 Regional MINT Memory Clinic
Referral Form for Non-FHTs

P: 226-338-5942 F: 1-888-205-1491

Name of referring physician:		
Client's name:	**Date of birth:**	**Telephone:**
Address:	**City:**	**Postal Code:**
Health card number:		**VC:**
Alternate Contact (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 assessed:	**❑Yes**	**❑No**
***** REFERRAL MAY BE DECLINED IF CLIENT HAS NOT BEEN INFORMED *****		
Delirium has been ruled out:	**❑Yes**	**❑No**
URGENT referral (please explain urgency below):	**❑Yes**	**❑No**

Reason for referral including relevant medical history:

PLEASE INCLUDE copies of all relevant documents:	**PLEASE INCLUDE the following if available:**
❑Consult report / specialist report	**❑CBC**
❑Previous cognitive testing	**❑TSH**
❑EKG	**❑Creatinine**
❑CT Scan / MRI reports	**❑Electrolytes**
❑Current medication list	**❑Glucose**
❑Patient profile	**❑Vitamin B12**
❑Significant medical history	**❑Calcium**

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

Phone Number: _____ **Fax Number:** _____

Physician Signature: _____ **Date:** _____