Niagara Medical Group Family Health Team

# MEMORY CLINIC REFERRAL

**Please fax back to 905-356-2765**
**Tel: 905-356-2236 ext. 254**

| | |
|---|---|
| **Patient Name:** | **Date of Birth:** |
| **Address:** | |
| | |
| **Health Care Number:** | **Version Code:** |
| **Telephone:** | |
| **Caregiver's Name:** | **Telephone:** |
| **Relationship to the family:** | |
| | |
| **Client/Family aware that a referral has been made?** ☐ Yes ☐ No | |
| **Reasons for the referral (please check):**<br>☐ Memory Loss<br>☐ Patient Concerns<br>☐ Difficulties with activities of daily living (ADL)<br>☐ Driving Suitability<br>☐ Family Concerns/Caregiver Stress | |
| **Please provide details:** | |
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| **The following labs are <u>REQUIRED</u>, and need to be attached with the referral (done within the last 6 months):**<br>☐ CBC ☐ Electrolytes ☐ Chloride<br>☐ HbA1C ☐ Vitamin B12<br>☐ TSH ☐ Calcium<br>☐ Creatinine ☐ ECG | **PLEASE attach the following with the referral:**<br>☐ Medical history **(required)**<br>☐ Current medication list **(required)**<br>☐ Head CT scan/MRI **(if available)**<br>☐ Consult report /Specialist reports<br>☐ MOCA **(if completed)** |
| ☐ ***** Please <u>INFORM</u> the patient prior to referring that driving concerns/capacity will be addressed at this assessment. ***** | |
| **Referring Physician Name:** | **Referring Physician Signature:** |
| **Referring Physician OHIP Billing Number:** | **Referral Date:** |
| **Referring Physician Fax Number:** | |