

MEMORY CLINIC REFERRAL FORM

University Health Network Memory Clinic

Memory Clinic 399 Bathurst St., 5WW Toronto, ON M5T 2S8 Phone; 416-603-5232 Fax: 416-803-6402

DATE:	MRN:		
	PATIENT INFORMATION		
NAME:			
ADDRESS:			
PHONE #;			
HEALTH CARD #;	VERSION CODE: EXP DATE:		
DATE OF BIRTH:		*	
WHAT LANGUAGE DOE	S THE PATIENT SPEAK	,	
MOST FREQUENTLY AT	HOME?	*	
	CONTACT INFORMATION		
PERSON TO CONTACT	FOR APPT:		
HOME PHONE:			
WORK PHONE:			
FAX #:			
	ILY PHYSICIAN INFORMATION		
NAME;			
ADDRESS:			
PHONE #:	FAX #:		
	IRING PHYSICIAN INFORMATIC		
SAME AS ABOVE:	YES	NO	
OHIP PROVIDER #:			
NAME:	A., A.		
ADDRESS:			
PHONE #:	FAX #;		
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REASON FOR REFERRA	Mari		
			

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MEDICAL HISTORY:			
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MEDICATIONS:			
MEDICA HONS:			
			
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LAB AND DIAGNOSTIC (PLEASE INCLUDE CB	ELECTO! V	TER FASTING	GLUCOSE, CALCIUM,
(PLEASE INCLUDE CH	DRA EALAT	E AND ECGI:	
CREATININE, TSH, B12	, MOU POLA	C WIND MOAL.	
	MAN COMPLE	TEN FORM	
PLEASE FAX (416-603-	MAN COMILTE	SIEDI OIM	
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