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

# MEMORY CLINIC REFERRAL FORM

DATE: _____ MRN: _____

## PATIENT INFORMATION

NAME: _____
ADDRESS: _____
PHONE #: _____
HEALTH CARD #: _____ VERSION CODE: EXP DATE:
DATE OF BIRTH: _____
WHAT LANGUAGE DOES THE PATIENT SPEAK MOST FREQUENTLY AT HOME?

## CONTACT INFORMATION

PERSON TO CONTACT FOR APPT:
HOME PHONE: _____
WORK PHONE: _____
FAX #:

## FAMILY PHYSICIAN INFORMATION

NAME: _____
ADDRESS: _____
PHONE #: FAX #:

## REFERRING PHYSICIAN INFORMATION

SAME AS ABOVE: YES NO
OHIP PROVIDER #:
NAME: _____
ADDRESS: _____
PHONE #: FAX #:

**REASON FOR REFERRAL:** _____

**MEDICAL HISTORY:**

**MEDICATIONS:**

**LAB AND DIAGNOSTIC TESTS**
**(PLEASE INCLUDE CBC, ELECTOLYTES, FASTING GLUCOSE, CALCIUM, CREATININE, TSH, B12, RBC FOLATE AND ECG):**

PLEASE FAX (416-603-5400) COMPLETED FORM.

**PLEASE NOTE:** INCOMPLETE REFERRAL FORMS WILL NOT BE PROCESSED AND THE PATIENT WILL NOT BE GIVEN AN APPOINTMENT. PLEASE ATTACH ANY RELEVANT PATIENT RECORDS THAT MAY BE OF HELP. IF ANY NEUROIMAGING HAS BEEN PERFORMED, PLEASE FORWARD THE FILMS/CD TO US.

PATIENTS WHO ARE NOT ACCOMPANIED TO THE CLINIC BY A FAMILY MEMBER OR FRIEND WHO CAN PROVIDE COLLATERAL HISTORY, WILL NOT BE SEEN.

| FOR OFFICE USE ONLY | | | |
|---|---|---|---|
| Date received: | | | Date Approved by RK: |
| 1 | 2 | 3 | Date Pkg sent: |
| Mon/Tues/Other Appt: | | | Date of confirmation: |
| Tentative Appt: | | | Confirm with: |