

MINT Memory Clinic Referral

***Please ensure that the referral is filled out completely. Incomplete referrals will be returned.**

Patient Information

Last Name: _____ First Name: _____
 DOB: _____ *HC#: _____ VC: _____
 Address: _____ ☐ M ☐ F ☐ Other: _____
 Primary language: ☐ English ☐ French ☐ Other: _____
 Phone: _____ Cell: _____ Email: _____

Pharmacy Information – this allows us to complete a best possible medication history prior to the appointment.

*Pharmacy Name: _____ *Phone: _____
 Address: _____

Is the patient/family aware that referral has been made? Y ☐ N ☐

The patient has previously seen: ☐ Geriatrician ☐ Memory Clinic ☐ GAIN team ☐ Neurology

Alternate Contact

Last Name: _____ First Name: _____ Relationship: _____
 Phone: _____ Email: _____
☐ *Check here to indicate that you **recommend AND have the patient's verbal consent** for the Memory Clinic staff to **contact the person listed above** about this referral.

Reason for Referral

☐ Change in behaviour / personality ☐ Delusions / Hallucinations
☐ Cognition / Memory ☐ Depression / Anxiety: *Is this a longstanding psychiatric concern?* Y ☐ N ☐
☐ Other/Comments: _____

Additional Information

☐ Lives alone ☐ Frequent falls ☐ Safety concerns ☐ *Driving ☐ Recent hospitalization
***Driving:** Our assessments elicit information about driving safety. By law, this may lead to the initiation of a report to the Ministry of Transportation. Patients must be made aware of this.
Patient is aware that driving safety will be part of the assessment? Y ☐ N ☐
Please attach the following investigations (within 1 year) if available.
☐ CBC ☐ Vitamin B12 ☐ MRI (head) ☐ CT (head) ☐ Cardiology Consult note
☐ TSH ☐ Creatinine ☐ Glucose / HbA1C ☐ ECG
☐ Electrolytes ☐ Previous MoCA ☐ Community Pharmacy Medication Check

Referring Primary Care Provider

Name: _____ Billing #: _____
 Signature: _____ Date: _____