

## 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: \_\_\_\_\_