MEMORY CLINIC REFERRAL FORM

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

WE DO NOT ACCEPT PATIENTS WHO HAVE THE FOLLOWING CONDITIONS:

- Under 55 without a family history of early onset dementia, a language disorder or a marked change in personality/behavior
- Developmental disorders/delay
- Major traumatic brain injuries
- Active history of alcohol and/or substance dependence or abuse
- Active psychiatric illness
- Has already been diagnosed with a dementia disorder

DATE: _____ **MRN:** _____

PATIENT INFORMATION			
NAME			
ADDRESS			
PHONE # (s)			DATE OF BIRTH____/____/____/ dd / mm / yy
HEALTH CARD #		VERSION CODE:	EXP. DATE: ___/ ___/ ___/
HOW WOULD YOU RATE THE PATIENT'S ABILITY TO SPEAK AND UNDERSTAND ENGLISH?			
Very well □	Well □	Not very well □	Not at all □
	Preferred language for appointment:		

CONTACT PERSON FOR APPOINTMENT (FAMILY/CAREGIVER/FRIEND)	
NAME	
HOME PHONE	
WORK PHONE	
FAX #	

REFERRING PHYSICIAN INFORMATION	
OHIP PROVIDER #	
NAME	
ADDRESS	
PHONE	FAX

FAMILY PHYSICIAN INFORMATION		
SAME AS ABOVE	YES □ NO □	
OHIP PROVIDER #		
NAME		
ADDRESS		
PHONE		FAX

REASON FOR REFERRAL:

IS THIS PATIENT AT RISK FOR FALLS?	**YES** □	**NO** □

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Please give the attached page on prevention strategies to patient and family.

MEDICAL HISTORY:

MEDICATIONS: Please remind your patient to bring in their medications to their appointment

LAB & DIAGNOSTIC TESTS:
Please include CBC, electrolytes, fasting glucose, calcium, creatinine, TSH, B12, RBC folate and ECG.
-*If any neuroimaging has been performed, please forward the CD to us.
PLEASE ATTACH A COPY OF THE PATIENT'S MOST RECENT COGNITIVE ASSESSMENT (MoCA, MMSE)

Incomplete and/or illegible referral forms **will not be processed**. **WE REQUIRE** that a family member or friend who is in close contact with the patient also attend the appointment.

PLEASE FAX COMPLETED FORM TO (416) 603-6402

FOR OFFICE USE ONLY			
Date received:			Date approved by RK:
1	2	3	
□ Tuesday Clinic		□ Dr. Tartaglia	Date package sent:
□ As per physician's schedule		□ Dr. Tang-Wai	Date of confirmation:
□ Resident Clinic		□ Dr. Keren	Confirmed with:
□ TRI Clinic		□ Dr. D. Weaver	

Krembil Neuroscience Centre Ambulatory Clinics
Falls Prevention in the Hospital

PREPARING TO COME TO YOUR APPOINTMENT

□ Please make sure that you bring your cane or walker to help you walk in the hospital.

□ Please make sure that you are wearing shoes that fit well and have non-slip soles.

□ Please bring your eye glasses (if you wear them) and hearing aid (if you use them) to the appointment.

□ If you have difficulties transferring from chair to walking, please bring someone to assist you if you can.

AT THE HOSPITAL

□ If you have problems walking long distances and do not have your own wheelchair, please enter the hospital at one of the main entrances where there is a supply of wheelchairs to assist you.

□ When you arrive at the Clinic, please let the receptionist know that you have difficulties walking.

□ Call for help if you feel weak or dizzy, for example when in or out of a chair or on or off the examination table.

□ Do not lean on equipment for support. Most hospital equipment is on wheels

□ Let us know if we have missed something and how we can assist you to protect you from falling.