MINT™ memory clinic
collaborative primary care

Primary Care Memory Clinic Referral Form for Non-FHTs

Ph: 226-338-5942 Fax: 1-888-205-1491

Name of referring physician:		
Client's name:	Date of birth:	Telephone:
Address:	City:	Postal code:
Health card number:		VC (if applicable):
Alternate contact person (REQUIRED):	Relationship:	Telephone:

Client previously seen by geriatrician or Memory Clinic:	❑ Yes	❑ No
Client / family aware that referral has been made:	❑ Yes	❑ No
Client has been informed that driving safety will be addressed:	❑ Yes	❑ No

Referral may be declined if the client has not been informed

Reason for referral including relevant history (if this referral is considered medically urgent, please provide reasons):

URGENT referral:	❑ Yes	❑ No
Delirium has been ruled out:	❑ Yes	❑ No

PLEASE INCLUDE copies of all relevant documents:

- ❑ Consult report / specialist report
- ❑ Previous cognitive testing
- ❑ EKG
- ❑ CT Scan / MRI reports
- ❑ Current medication list
- ❑ Significant medical history

PLEASE INCLUDE the following blood work if available:

- ❑ CBC
- ❑ TSH
- ❑ Creatinine
- ❑ Electrolytes
- ❑ Glucose
- ❑ Vitamin B12
- ❑ Calcium

Physician Name: ________________________________ OHIP Billing #: ________________________________

Physician Signature: ____________________________ Date: ________________________________