541 Glenridge Avenue, St. Catharines, ON L2T 4C2
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Memory Clinic Referral Form

The HDSHRC Memory Clinic is intended to support practices in the assessment and management of patients with memory issues. Patients referred to the Memory Clinic will receive:

♦ Cognitive Assessment (**includes DRIVING ASSESSMENT**) ♦ Medication Review
♦ Connections to Community Supports

After the appointment the Family Doctor will receive clear, comprehensive recommendations for follow-up.
** Caregiver / family are required to attend the appointment with the patient.

➔ **We do not see patients already seen by GAP, GMHO or Geriatrics.**

PATIENT INFORMATION

Gender: M ❒ F ❒ Date of Birth: Month ______________ Day ______ Year ________

Last Name __________________________________ First Name ____

Street __________________________________ City / Town _________________________ Postal Code _____________

Health Card No. _____________________________ Home Telephone __________________ Business/Cell Telephone _________________

Caregiver's Name ____ Telephone _________________

Relationship to Patient __________________________ Client/family aware that referral has been made? ❒ Yes ❒ No

REASONS FOR REFERRAL

Concerns: ____

____

Is this referral URGENT? ❒ **Yes** (Urgent Referrals should be seen within 6 weeks)
❒ **No** (Non-urgent referrals should be seen within 3 months)

Nature of Urgency: ____

MEDICAL INFORMATION

If the patient is being referred for a cognitive assessment, **PLEASE ENSURE** that any pertinent investigations be Included:

- ☐ Consult report
- ☐ EKG
- ☐ Current medication list
- ☐ Significant medical history
- ☐ Patient has been informed that driving concerns will be addressed at this assessment

PLEASE ENSURE the following bloodwork is forwarded with the referral if available:

- ☐ CBC
- ☐ TSH
- ☐ Creatinine
- ☐ Electrolytes
- ☐ Glucose
- ☐ Vitamin B12
- ☐ Calcium .

Referring Physician ______________________________________ Telephone No. ______________________________

Billing #: ________________ Address ____

______________________________________ ______________________________________
Referral Date Referring Physician's Signature