541 Glenridge Avenue, St. Catharines, ON L2T 4C2
Tel: 905-685-1381 Fax: 905-688-9905

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 (Geriatric Assessment Program), NSMHO (Niagara Seniors Mental Health Outreach) or Geriatrics, or have an extensive history of mental health as their main concern or complex neuro history, eg. progressive supra nuclear palsy, hydrocephalus or brain injury.**

PATIENT INFORMATION

Gender: M ❒ F ❒ Date of Birth: Day ________ Month _______________ Year _________

Last Name ____________________________________ First Name ____

Street ____________________________________ City / Town __________________________ Postal Code ______________

Health Card No. _______________________________ Home Telephone ___________________ Business/Cell Telephone __________________

Preferred Language ____

Caregiver's Name ____ Telephone __________________

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

REASONS FOR REFERRAL

Time of onset, details of what the concern is: ____

____

MEDICAL INFORMATION REQUIRED TO BE SEEN

- ☐ Cognitive testing – if done
- ☐ Consult report
- ☐ EKG
- ☐ Current medication list
- ☐ Significant medical history
- ☐ Patient has been informed that driving concerns will be addressed at this assessment
- ☐ Driving ❒ Yes ❒ No

- ☐ CBC
- ☐ TSH
- ☐ Creatinine
- ☐ Electrolytes
- ☐ Glucose
- ☐ Vitamin B12
- ☐ Calcium
- ☐ HbA1c
- ☐ Albumin

Referring Physician ____ Telephone No. _________________________________

Billing #: ________________ Address ____

____ ____
Referral Date Referring Physician's Signature