



**MINT[®]
MEMORY
CLINIC**

Collaborative primary care

**MINT Memory Clinic
Referral Form**

P: 519-778-2546 F: 519-293-3941

Name of referring physician:		
Client's name:	Date of birth:	Telephone:
Address:	City:	Postal Code:
Health card number:		VC:
Alternate contact (REQUIRED):	Relationship:	Telephone:
Client previously seen by Geriatrician or Memory Clinic: <input type="checkbox"/> Yes <input type="checkbox"/> No Client / family aware that referral has been made: <input type="checkbox"/> Yes <input type="checkbox"/> No Client has been informed that driving safety will be assessed: <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">*** REFERRAL MAY BE DECLINED IF CLIENT HAS NOT BEEN INFORMED ***</p>		
Reason for referral including relevant medical history (if considered medically urgent, please provide reasons):		
URGENT referral: <input type="checkbox"/> Yes <input type="checkbox"/> No Delirium has been ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No		
PLEASE INCLUDE copies of all relevant documents: <input type="checkbox"/> Consult report / specialist report <input type="checkbox"/> Previous cognitive testing <input type="checkbox"/> EKG <input type="checkbox"/> CT Scan / MRI reports <input type="checkbox"/> Current medication list <input type="checkbox"/> Patient profile <input type="checkbox"/> Significant medical history		PLEASE INCLUDE the following if available: <input type="checkbox"/> CBC <input type="checkbox"/> TSH <input type="checkbox"/> Creatinine <input type="checkbox"/> Electrolytes <input type="checkbox"/> Glucose <input type="checkbox"/> Vitamin B12 <input type="checkbox"/> Calcium
Physician Name: _____		OHIP Billing #: _____
Physician Signature: _____		Date: ____