MINT® MEMORY CLINIC
Collaborative primary care

MINT Memory Clinic Referral Form

P: 519-778-2546 F: 519-293-3216

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: ❑Yes ❑No

Client / family aware that referral has been made: ❑Yes ❑No

Client has been informed that driving safety will be assessed: ❑Yes ❑No

*** REFERRAL MAY BE DECLINED IF CLIENT HAS NOT BEEN INFORMED ***

Reason for referral including relevant medical history (if 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
- ❑ Patient profile
- ❑ Significant medical history

PLEASE INCLUDE the following if available:

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

Physician Name: _____ OHIP Billing #: _____

Physician Signature: _____ Date: _____