Alzheimer Society DURHAM REGION

In collaboration with:

seniors care network

Ontario Central East Local Health Integration Network

PRIMARY CARE COLLABORATIVE MEMORY CLINICS

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REFERRAL FORM – Scarborough

LAST NAME: FIRST NAME:

HC#: VC: DOB: ☐ M ☐ F

ADDRESS:

PHONE: CELL:

PRIMARY LANGUAGE: _____

Korean, Cantonese and Tamil interpretation is available. For any other languages, please ensure the client brings an interpreter.

☐ **RECOMMENDATIONS ONLY** – rather than our routine management which includes medication adjustments, ordering investigations and arranging referrals as appropriate, please check to indicate that you would prefer recommendations only from the Memory Clinic team.

☐ Please check here to indicate that the patient has been informed that, by law, **DRIVING SAFETY WILL BE PART OF THE ASSESSMENT**

☐ Please check here to indicate that you **both recommend AND have** the patient's verbal **consent** for the Memory Clinic team ***to contact an alternate person*** in order to arrange this appointment. If so, please include:

Alternate Contact Person: _____ Relationship: _____

Phone Number(s): _____ OR _____

Reason for Referral:

☐ Cognition / Dementia
☐ Depression / Anxiety
☐ Responsive Behaviours
☐ Delusions / Hallucinations
☐ Other / Comments:

Recommended labs:

☐ CBC
☐ TSH
☐ Creatinine
☐ Sodium
☐ Glucose
☐ HbA1C
☐ Vitamin B12
☐ Calcium

☐ **URGENT APPT REQUESTED? Please provide details:**

Referring Physician:	Billing #:
Signature:	Date: