135 Queen's Plate Dr. Suite 120
Etobicoke, On M9W 6V1
Phone: 416-342-5140 Fax: 416-342-5148

- ☐ Dr. Rikhye
- ☐ Dr. Lacko
- ☐ Dr. Bokore
- ☐ Namdeep Virdi NP

MEMORY CLINIC REFERRAL

Patient's Name:	Date of Birth:	Telephone:
Address:	City:	Postal Code:

Health Card Number:	VC:

Contact person's Name:
Relationship to patient:
Can we contact this caregiver for reminders: Yes/ No
Contact info. caregiver: (H) (Mobile) email:

Patient /support person aware that referral has been made? ☐ **Yes** ☐ **No**

Have you been ever been evaluated for memory concerns by another physician in the past ☐**Yes** ☐**No**

Please indicate current or pending:
☐ Court proceeding ☐ WSIB Claim ☐ Insurance claim ☐ Disability Pension Claim

Note: We **DO NOT** do competency assessment

Reasons for the Referral (please check):

- ☐ Cognition / Dementia
- ☐ Depression / Anxiety
- ☐ Behavioural Difficulties
- ☐ Delusions / Hallucinations
- ☐ Caregiver Stress
- ☐ Psychosocial
- ☐ Wandering/Safety Concerns:

Comments:

***PLEASE ENSURE* that any pertinent investigations be included:**

- ☐ Consult report / Specialist report
- ☐ EKG
- ☐ CT Scan / MRI
- ☐ 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 Name: ______________________ **Physician Signature:** ________________________________

M. D. Billing # : _____________________________ **Date:** ______________________