WOODBINE FAMILY HEALTH TEAM
135 Queen's Plate Dr. Suite 120, Toronto, On M9W 6V1
Phone: 416-342-5140 Fax: 416-342-5148

Woodbine Family Health Team:
Memory Clinic Referral Form

Patient Name:	DOB:	Telephone:	
Address:	City:	Postal Code:	
HC Number: VC:		M / F	Age:
Primary Language: _____ Is interpreter needed?		Yes	No
Contact person's Name: *(**Required)*	Ph: M:	Email:	
Relationship to patient:	Alt. ph. # for patient:		

Patient previously seen by Geriatrician or Memory Clinic?: ☐Yes ☐No
Patient/family aware that referral has been made?: ☐Yes ☐No
Patient has been informed that driving safety will be assessed?: ☐Yes ☐No – **May be declined if not informed****

Patient must have baseline CT Scan prior to Memory Clinic Referral – May be declined without one*

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 all that apply):

☐ **Cognition / Dementia**	☐ **Caregiver Stress**	☐ **Depression / Anxiety**
☐ **Psychosocial Issues (ie. Elder abuse)**	☐ **Wandering/Home Safety Concerns**	☐ **Functional/ADL Decline**
☐ **Frequent Unexplained Falls**	☐ **Delusions / Hallucinations**	☐ **Behavioural Difficulties**

Please give more written details of reason for referral and some history of memory issues and social issues facing patient:

Urgent Referral? ☐Yes ☐No Reason: _____

PLEASE INCLUDE copies of all relevant documents: ☐Consult/specialist report (if relevant) ☐Previous cognitive testing ☐EKG ☐Previous CT Scan/MRI reports ☐Patient profile & Current medication list ☐Significant medical history	Please include the following within the last 12 mons: ☐CBC ☐TSH ☐Creatinine ☐Electrolytes ☐Glucose ☐Serum Vitamin B12 ☐Serum Calcium

Referring Physician: _____	OHIP Billing #: _____
Physician Signature: _____	Date: _____

Fax Completed Referral Form and Attachments to (416) 342-5148