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:
Contact person's Name: *(**Required)*	Ph: M:	Email:	
Relationship to patient:	Alt. ph. # for patient:		

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 *

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

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

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