Toronto Memory Program

Referral Form

Fax to (416) 386-0458

Patient Identification
Name:
Address:
Telephone:
DOB:
HCN:

Contact Person
Name:
Relationship:
Telephone (H):
Telephone (B):
Mobile:

Referral for Memory Clinic Services (check all that apply)
Note that services with an asterix are not covered by OHIP

- ❑ Cognitive impairment/ Dementia diagnosis/ Management
- ❑ Dementia education/ Counseling/ Family mediation
- ❑ Competency assessment (specify issue)_____
- ❑ Mindfulness-Based Stress Reduction for Caregivers (course partially covered by OHIP)
- ❑ Communication Therapy for Adults*
- ❑ Cognigram computerized cognitive testing*
- ❑ Review of Cognigram results with patient by memory clinic physician
- ❑ Specialized Driving Assessment/Driver Rehabilitation*

Referral for General Neurology

- ❑ Specify problem: _____

Referral for Clinical Trial Opportunities

- ❑ Interested in clinical trial options
- ❑ Interested in a particular trial (specify trial) _____

Past Medical History and Medications (please list below or attach)

Investigations (check those available and attach reports)

- ❑ **No investigations to date**
- ❑ **Last MMSE score __/30**
- ❑ **Last MoCA score __/30**
- ❑ **Recent Blood work**
- ❑ **CT brain scan**
- ❑ **MRI brain scan**
- ❑ **SPECT brain**
- ❑ **Consultation or progress notes**
- ❑ **Other**_____

Referring MD:
Billing No:
Signature:

Phone:
Fax No:
Email:

AF/TMP Referral Form April 23, 2015

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