Baycrest Enriching Care Enhancing Knowledge Enlightening Minds

SAM & IDA ROSS MEMORY CLINIC – REFERRAL FORM
3560 Bathurst Street 6th Floor, Brain Health Complex
Toronto, Ontario M6A 2E1
TEL: (416) 785-2444 FAX: (416) 785-2484

Please note that the Memory Clinic does NOT accept patients for assessment or management of the following disorders:

- Developmental disorders (e.g., ADHD, learning disorder)
- Chronic fatigue syndrome
- Occupational and environmental exposures
- Traumatic brain injury
- Alcohol or substance dependence or abuse

Name of Client _____ ❑ Male ❑ Female

Date of Birth _____ Marital Status _____

Street Address _____ Apt. # _____ City _____

Province _____ Postal Code _____ Phone # _____

Health Card # _____/_____/_____ Version Code_____

Is client fluent in English? ❑ Yes ❑ No If "No", what language is spoken at home?_____

***If an Interpreter is required, the client must bring him/her to all appointments.**

Name of person to contact re: booking appointment: _____

Relationship to client: _____ Phone # (daytime) _____

Phone # (evening) _____

Purpose of assessment: ❑ Consultation only ❑Consultation and follow-up

Please indicate reason for referral: (can check more than one box)

Cognitive

❑ Dementia with onset age 65+ ❑ Dementia with onset < age 65 ❑ Mild memory problems
❑ Other: _____

Behavioural

❑ Verbal / physical aggression ❑ Wandering ❑ Screaming
❑ Hoarding ❑ Inappropriate behaviour ❑ Other: _____

Other clinical issues

❑ Delusions ❑ Hallucinations ❑ ADL/IADL
❑ Need for community resources ❑ Caregiver / family stress ❑ Medication management
❑ Home safety ❑ Safety to Drive ❑ Other: _____

NOTE: Recent blood work (within last 6 months) is required. Please provide the following:

- CBC
- Fasting blood sugar
- Electrolytes
- Calcium
- Creatinine & eGFR
- Vitamin B12
- sTSH

Our clinic also requires the following information, if available:

❑ Prior CT or MRI ❑ Prior psychiatry clinical summaries
❑ Prior SPECT ❑ Prior consultations for cognitive impairment
❑ Prior neuropsychology reports

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Patient Name _____ Date of Birth _____

Current Medications _____

Additional Comments _____

Name of Family MD *(please print)*	Phone:	Fax:
Name of Referring MD *(please print)*	Phone:	Fax:
Date (d*d/mm/yy)*	Ohip Billing#:	