Burlington Family Health Team
Memory Clinic

Physician Referral Form
Phone: 289-861-5611 Fax: 1-855-764-8360

PHYSICIAN REFERRAL REQUIRED

Name of referring physician:		
Client's name:	**DOB:**	**Telephone:**
Address:	**City:**	**Postal Code:**
Health Card:		**VC:**
Name of family physician:		
Name of Alternate contact (REQUIRED):	**Relationship:**	**Telephone:**

Best person to contact: ☐ Client ☐ Alternate Contact

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 THAT DRIVING SAFETY WILL BE ASSESSED**

Reason for referral including relevant medical history (if considered medically urgent, please provide reasons):

URGENT referral: ☐ Yes ☐ No

Delirium has been ruled out: ☐ Yes ☐ No

PLEASE INCLUDE copies of all relevant documents:

- ☐ Consult report / specialist report
- ☐ Previous cognitive testing
- ☐ EKG
- ☐ CT Scan / MRI reports
- ☐ Current medication list
- ☐ Patient profile
- ☐ Significant medical history

PLEASE PROVIDE the following bloodwork results from within the last 6 months:

- ☐ TSH
- ☐ CBC
- ☐ Creatinine
- ☐ Electrolytes
- ☐ eGFR
- ☐ Glucose
- ☐ HbA1C
- ☐ Vitamin B12
- ☐ Vitamin D levels

Physician Name: _____ **OHIP Billing #:** _____

Physician Signature: _____ **Date:** _____