Burlington Family Health Team (BFHT)
Memory Clinic Referral Form

PHYSICIAN REFERRAL REQUIRED

Phone: 289-861-5611 • Fax form to: 1-855-764-8360

Name of referring physician:		
Client's name:	Date of birth:	Telephone:
Address:	City:	Postal Code:
Health card number:		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 **actively** seen by Geriatrician or Memory Clinic:	☐ Yes	☐ No
Client / family aware that referral has been made:	☐ Yes	☐ No
Client has active driver's license:	☐ 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 <u>(if considered medically urgent, please provide reasons):</u>

URGENT referral: ☐ Yes ☐ No

Delirium has been ruled out: ☐ Yes ☐ No

<u>PLEASE INCLUDE</u> 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

<u>PLEASE PROVIDE the following bloodwork results from the last 6 months:</u>

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

Physician Name: _____ OHIP Billing #: _____

Physician Signature: _____ Date: _____