Rapids
Family Health Team
1150 Pontiac Dr., Sarnia ON N7S 3A7
Fax : 519-491-2371

Memory Clinic Primary Care Provider Referral Form

The Rapids Family Health Team Memory Clinic is intended to support practices in the assessment and management of patients with memory issues. The Rapids FHT Memory Clinic serves as a first point of access for individuals with memory concerns to facilitate early intervention and diagnosis of memory issues. We do this through conducting cognitive assessments (including driving assessment), medication review, connections to community supports, primary care provider will receive clear, comprehensive recommendations for follow-up.

WE DO NOT ACCEPT PATIENTS WHO HAVE THE FOLLOWING CONDITIONS:

•Patients diagnosed and treated for dementia disorder (see flow chart for specifics) • Untreated Psychatric Disorders •Developmental disorders/delay •Active history of alcohol/substance dependence or abuse

Client Information: Referral Date:

Name:	OHIP #:
Address:	
Phone: (home) (cell)	DOB:
Family Doctor:	

*****NOTE: The following information is REQUIRED. Incomplete referral forms will NOT be processed.*****

****We require that a Patient Information Form MUST be completed with the referral. ****

Caregiver/family REQUIRED to attend appointment with patient

Client previously seen by geriatrician or Memory Clinic:	☐ Yes	☐ No
Client/family aware that the referral has been made:	☐ Yes	☐ No
Client has been informed that **driving safety** will be addressed and potential **risk** of assessment is **license suspension**	☐ Yes ☐Current Driver	☐ No - *Does not drive*

Reason for Referral/Diagnostic Question:

Clinical Details: *Check all that apply* (if this referral is considered **medically urgent**, please call the office @519-339-8949):

☐Cognitive function impacting ability to do ADLs (personal care), ☐ iADLs (finances, driving, household management , etc.)

☐Date/onset of issues: _____

OTHER CLINICAL ISSUES: ☐Safety to Drive ☐Lives alone ☐Concern re: safety/medication ☐ History of Falls

☐ Psychiatric symptoms (depression, anxiety, etc.) ☐ Responsive behaviours (agitation, aggression, wandering, etc.)

☐ Delusions/hallucinations/paranoia

HISTORY/DETAILS: ☐TIA/CVA ☐Traumatic Brain Injury ☐MI ☐Diabetes ☐Organic sleep disorder ☐Cancer:_____

☐ Other *(list):*

THE FOLLOWING ARE REQUIRED TO PROCESS REFERRAL: *****Referrals with incomplete information will NOT be processed*****

- **Recent bloodwork (≤ 3 months)** - CBC, TSH, Glucose/A1C, Creatinine, Vitamin B12, Calcium, Electrolytes, Albumin, Ammonia, Lipids/Chol
- Medication List
- Significant medical history, relevant specialist reports
- **Recent ECG/EKG (≤ 3 months)** *(for medication prescription purposes)*
- Brain Imaging/MRI *(include if on file)*
- Previous cognitive tests *(include if on file)*

Alternate Contact Is Required: ☐Translation required for assessment? Y / N

Name:	Relationship to Client:
Address:	Phone: (home) (cell)
POA: ☐ Yes ☐ No If No, please specify POA	