Superior Family Health Team

Memory Clinic Referral Form

Patient Name:_____

Address:_____ **City**:_____

Postal Code:_____ **Date of Birth**:_____

Health Card #_____ **Primary Care Provider**:_____

Power of Attorney: ☐Yes ☐No **Substitute Decision Maker**: ☐Yes ☐No

If yes, please specify who:_____

Allergies:_____

Medication List: ☐List Attached or complete below

Drug	Dosage	Frequency	Indication

Medical History: ☐List Attached or complete below

Date of Onset	Diagnosis

Patient Name:_____

Surgical History:

Date of Surgery	Diagnosis Details

Labs: Please include the following labs (done within last 3 months)-CBC, TSH, creatinine, calcium, HbA1C, glucose, vitamin B12 level.

Diagnostic Imaging: Include CT Head, MRI and Carotid Dopplers if available.

Summary of Symptoms: _____

_____

_____

_____

_____

Past Rx response:_____

_____

_____

_____

Have you discussed the Memory Clinic with your patient and/or their family? ☐Yes ☐No

If No please do so and obtain consent from patient/Power of Attorney to participate.

Name of person submitting referral:_____

Please fax completed referral and accompanying documents to: (705) 253-9668.

For more information, please call Samarita at (705) 253-6599.