MINT MEMORY CLINIC
Collaborative primary care

Carefirst Seniors & Community Services Association
MINT Memory Clinic
300 Silver Star Blvd, 2nd Floor, Scarborough, ON. M1V 0G2
Phone: 416-847-8940; Fax: 416-646-5109
Email: info.specialist@carefirstontario.ca
Referrals: *Ocean Healthmap* RE: "Carefirst MINT Memory Clinic"

Carefirst

MINT Memory Clinic Referral

*Please ensure that the referral is filled out completely. **Incomplete referrals will be returned.**

Patient Information

Last Name: First Name:

DOB: *HC#: VC:

Address: ☐ M ☐ F ☐Other:

Primary language: ☐ English ☐ French ☐Other:

Phone: Cell: Email:

Pharmacy Information – this allows us to complete a best possible medication history prior to the appointment.

*Pharmacy Name: *Phone:

Address:

Is the patient/family aware that referral has been made? Y ☐ N ☐
The patient has previously seen: ☐ Geriatrician ☐ Memory Clinic ☐ GAIN team ☐ Neurology

Alternate Contact

Last Name: First Name: Relationship:

Phone: Email:

☐ *Check here to indicate that you **recommend AND have the patient's verbal consent** for the Memory Clinic staff to **contact the person listed above** about this referral.

Reason for Referral

☐ Change in behaviour / personality ☐ Delusions / Hallucinations

☐ Cognition / Memory ☐ Depression / Anxiety: *Is this a longstanding psychiatric concern?* ☐Y ☐N

☐ Other/Comments:

Additional Information

☐ Lives alone ☐ Frequent falls ☐ Safety concerns ☐ *Driving ☐ Recent hospitalization

***Driving:** Our assessments elicit information about driving safety. By law, this may lead to the initiation of a report to the Ministry of Transportation. Patients must be made aware of this.

Patient is aware that driving safety will be part of the assessment? Y ☐ N ☐

Please attach the following investigations (within 1 year) if available.

☐ CBC ☐ Vitamin B12 ☐ MRI (head) ☐ CT (head) ☐ Cardiology Consult note

☐TSH ☐ Creatinine ☐ Glucose / HbA1C ☐ ECG

☐ Electrolytes ☐ Previous MoCA ☐ Community Pharmacy Medication Check

Referring Primary Care Provider

Name: Billing #:

Signature: Date:

In collaboration with:

Alzheimer Society DURHAM REGION

seniors care network

Ontario Health