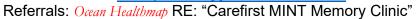


## Carefirst Seniors & Community Services Association MINT Memory Clinic

300 Silver Star Blvd, 2<sup>nd</sup> Floor, Scarborough, ON. M1V 0G2

Phone: 416-847-8940; Fax: 416-646-5109 Email: info.specialist@carefirstontario.ca





## 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: ☐ Englis	h □ 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 <b>recommend AND have the patient's verbal consent</b> for the Memory Clinic staff to <b>contact the person listed above</b> about this referral.				
Reason for Referral				
☐ Change in behaviour / personality ☐ Delusions / Hallucinations				
☐ Cognition / Memory	emory   Depression / Anxiety: <i>Is this a longstanding psychiatric concern?</i> Y N			
☐ Other/Comments:				
Additional Information				
☐ Lives alone	☐ Frequent falls	☐ Safety concerns ☐ *	*Driving □ Rece	nt 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 \( \subseteq \ N \)				
Please attach the following	,	• ,	□ <b>○</b> ▼	□ Cardiology Canault nata
□ CBC	☐ Vitamin B12	<ul><li>☐ MRI (head)</li><li>☐ Glucose / HbA1C</li></ul>	☐ CT (head)	☐ Cardiology Consult note
□TSH	☐ Creatinine		lucose / HbA1C □ ECG  pmmunity Pharmacy Medication Check	
☐ Electrolytes	☐ Previous MoCA		acy Medication C	
Referring Primary Care Pro	ovider			
Name:		Billing #:		
Signature:	Date:			

In collaboration with:





