Superior Family Health Team
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Sault Ste. Marie, ON P6A 2A8
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MEMORY CLINIC REFERRAL

Referral Source:		Billing Number:
Client's Name:	Date of Birth:	Telephone:
Address:	City:	Postal Code:
Health Card Number:		VC (if applicable):
Caregivers Name:	Telephone:	

Primary Care Provider/Client / family aware that referral has been made? ☐ Yes ☐ No

Reasons for the Referral (please check):

- ☐ Cognition / Dementia
- ☐ Depression / Anxiety
- ☐ Behavioural Difficulties
- ☐ Delusions / Hallucinations
- ☐ Caregiver Stress
- ☐ Psychosocial
- ☐ Wandering

Comments:

*If the patient is being referred for a cognitive assessment, **PLEASE ENSURE** that any pertinent investigations be included:*

- ☐ Consult report / Specialist report
- ☐ Brain Imaging (if available)
- ☐ Current medication list
- ☐ Significant medical history
- ☐ Patient has been informed that driving concerns will be addressed at this assessment
- ☐ Please attach consult request with summary of concerns.

***PLEASE ENSURE** the following bloodwork is forwarded with the referral :*

- ☐ CBC
- ☐ TSH
- ☐ Creatinine
- ☐ Electrolytes
- ☐ Glucose
- ☐ Vitamin B12
- ☐ Calcium
- ☐ Ecg

Primary Care Provider Name _____

Signature _____

Date: _____