



**Referral Form**  
**Fax to 416.386.0458**

**Patient Identification**

Name:  
Address:  
Telephone:  
DOB:  
HCN:

**Contact Person** ( patient aware)

Name:  
Relationship:  
Telephone (H):  
Telephone (B):  
Mobile:

**Reason for Referral to Toronto Memory Program (check one or more)**

- Memory impairment \_\_\_\_\_
- Dementia diagnosis \_\_\_\_\_
- Dementia management \_\_\_\_\_
- Interest in clinical trials \_\_\_\_\_
- Competency assessment (specify issue) \_\_\_\_\_
- Dementia education and/ or counseling \_\_\_\_\_
- Other: \_\_\_\_\_

**Past Medical Hx**

**Medications**

**Investigations (Please check all available and fax with this referral)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Last MMSE score ___/30    | <input type="checkbox"/> Last MoCA score ___/30    | <input type="checkbox"/> Blood work (including TSH, B12) |
| <input type="checkbox"/> CT brain                  | <input type="checkbox"/> MRI brain                 | <input type="checkbox"/> SPECT brain                     |
| <input type="checkbox"/> Consults or other reports | <input type="checkbox"/> No investigations to date |  |

**Referring Physician:**

**Billing No:**

**Signature:**

**Phone:**

**Fax No:**