Sharon Cohen MD FRCPC
C.I.Cohen MD CCFP DipSportMed
Mihaela Nicula MD FRCPC
J. Thayaparan MD FRCPC
Ellen Buchman MD CCFP
Adriana Bida MD FRCPC
Sara Wainberg MD CCFP

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____
- ☐ Mindfulness-Based Stress Reduction for Caregivers ____________________________________
- ☐ Other: ____
____

Past Medical Hx

Medications for AD: ☐ **Yes** ☐ **No** ____

Other Medications:

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

☐ **Last MMSE score __/30** ☐ **Last MoCA score __/30** ☐ **Blood work (including TSH, B12)**
☐ **CT brain** ☐ **MRI brain** ☐ **SPECT brain**
☐ **Consults or other reports** ☐ **No investigations to date**

Referring Physician:
Billing No:
Signature:

Phone:
Fax No:

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