Toronto Memory Program

Referral Form

Fax to (416) 386-0458

Patient Identification
Name:
Address:
Telephone:
DOB:
HCN:

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

Memory Clinic Services (age ≥ 55 years***)**

- ❑ AD Prevention/ Risk Factor Assessment/ Baseline Cognitive Testing
- ❑ Cognitive Symptoms requiring Diagnosis/Management
- ❑ Mindfulness-Based Stress Reduction (8 week course partially covered by OHIP)
- ❑ Communication Therapy for Adults (non-OHIP service)
- ❑ Specialized Driving Assessment/Driver Rehabilitation (non-OHIP service)

*******exception to lower age limit applies to those with strong family history of Alzheimer's or FTD*

Clinical Trials (ages 50-85 years)

- ❑ Interested in clinical trial options
- ❑ Interested in a particular trial (specify trial) _____

Epilepsy Consultation/Management

- ❑ Specify problem: _____

General Neurology

- ❑ Specify problem: _____

Geriatric Psychiatry

- ❑ Specify problem: _____

Past Medical History and Medications (please attach CPP)

Required Investigations (please forward in advance of appointment):

❑ Blood work (including TSH and B12) ❑ MRI brain (CT brain if MRI contraindicated)

Additional Investigations (if available):

❑ Cognitive Tests ❑ Consult/progress notes ❑ Other_____

Referring MD:
Billing No:
Signature:

Phone:
Fax No:
Email:

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