



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
- 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: _____
- Migraine/Botox: _____

Movement Disorders Clinic Services

- Tremor
- Parkinson's disease
- Other – specify problem: _____

Past Medical History and Medications (please attach CPP)

Memory Clinic 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: