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

Movement Disorders Clinic Services
- ❑ Parkinson's disease □ Tremor □ Other:____

Other Neurological Problems
- ❑ Migraine____
  - □ Interested in Botox
- ❑ Epilepsy ____
- ❑ Other: ____

Clinical Trials only
- ❑ Alzheimer's disease (ages 50-90, prevention, MCI, dementia trials)
- ❑ Parkinson's disease (ages 50-90)
- ❑ Migraine (age 18+)

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:

AF/TMP Referral Form Nov.1, 2021

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