Niagara Medical Group Family Health Team

MEMORY CLINIC REFERRAL

Société Alzheimer Society NIAGARA REGION

Fax (905) 356-2765

Patient Name:	**Date of Birth:**
Address:	
Health Care Number:	**Version Code:**
Telephone:	
Caregiver's Name:	**Telephone:**
Relationship to the family:	
Client/Family aware that a referral has been made? ☐ Yes ☐ No	

Reasons for the referral (please check):

- ☐ Memory Loss
- ☐ Patient Concerns
- ☐ Difficulties with activities of daily living (ADL)
- ☐ Driving Suitability
- ☐ Family Concerns/Caregiver Stress

- ☐ Mobile Assessment (in-home)*
- ☐ Community Assessment (in-office)

*for practitioners with no access to Memory Clinic Teams or patient is home bound

Mobile Assessment (in-home):

To be eligible for the Mobile Cognitive Assessor service, patients must meet specific criteria:

- Not have multiple complex medical conditions, complex responsive behaviours, significant mental health diagnoses, or new and worsening neurological symptoms. (Patients falling under these categories are encouraged to consider specialized services such as the Geriatric Assessment Program at Niagara Health, St. Joseph's Health Care: Niagara Region Mental Health program, or Neurology.)
- Not previously been assessed by specialized geriatric services.
- Do not have a diagnosis of intellectual disability. (Note: Patients with intellectual disability can access the Dual Diagnosis clinic through St. Joseph's.)
- Patients who are rostered with Family Health Teams (FHTs) and have access to the Primary Care Memory Clinic should be referred internally. The Mobile Cognitive Assessment service is available to homebound patients of FHTs with memory clinics.

Comments:

PLEASE ENSURE the following bloodwork is forwarded with the referral when available (done within the last 6 months):

- ☐ CBC
- ☐ HbA1C
- ☐ TSH
- ☐ Creatinine
- ☐ Electrolytes
- ☐ Vitamin B12
- ☐ Calcium
- ☐ ECG

PLEASE INCLUDE the following if available:

- ☐ Consult report /Specialist reports
- ☐ Head CT scan/MRI
- ☐ Current medication list
- ☐ Significant medical history

☐ *****Patient has been informed that driving concerns/capacity will be addressed at this assessment. *****

Physician Name:	**Physician Signature:**
Physician OHIP Number:	**Date:**
Physician Fax Number:	