Burlington Family Health Team
Memory Clinic

Physician Referral Form

Phone: 289-962-1064 Fax: 1-855-764-8360

PHYSICIAN REFERRAL REQUIRED

Name of referring physician:		
Client's name:	**Date of birth:**	**Telephone:**
Address:	**City:**	**Postal Code:**
Health card number:		**VC:**
Name of family physician:		
Name of Alternate contact (REQUIRED):	**Relationship:**	**Telephone:**
Best person to contact: ❑ Client ❑ Alternate Contact		

Client previously seen by Geriatrician or Memory Clinic: ❑Yes ❑No

Client / family aware that referral has been made: ❑Yes ❑No

Client has been informed that driving safety will be assessed:** ❑Yes ❑No

** REFERRAL MAY BE DECLINED IF CLIENT HAS NOT BEEN INFORMED THAT DRIVING SAFETY WILL BE ASSESSED**

Reason for referral including relevant medical history (if considered medically urgent, please provide reasons):

URGENT referral: ❑Yes ❑No

Delirium has been ruled out: ❑Yes ❑No

PLEASE INCLUDE copies of all relevant documents:

- ❑ Consult report / specialist report
- ❑ Previous cognitive testing
- ❑ EKG
- ❑ CT Scan / MRI reports
- ❑ Current medication list
- ❑ Patient profile
- ❑ Significant medical history

PLEASE PROVIDE the following bloodwork results from within the last 6 months:

- ❑ TSH
- ❑ CBC
- ❑ Creatinine
- ❑ Electrolytes
- ❑ eGFR
- ❑ Glucose
- ❑ HbA1C
- ❑ Vitamin B12
- ❑ Vitamin D levels

Physician Name: _____ **OHIP Billing #:** _____

Physician Signature: _____ **Date:** _____