



300 Silver Star Blvd, 2<sup>nd</sup> floor  
Scarborough, ON M1G 0V2  
Phone: 416-847-8941 Fax: 416-646-5111

## REFERRAL FORM – MINT Memory Clinic

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
HC#: \_\_\_\_\_ VC: \_\_\_\_\_ DOB: \_\_\_\_\_  M  F  
ADDRESS: \_\_\_\_\_  
PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

PRIMARY LANGUAGE: \_\_\_\_\_  
*Korean, Cantonese and Tamil interpretation is available. For any other languages, please ensure the client brings an interpreter.*

**RECOMMENDATIONS ONLY** – Post assessment, our routine management includes medication adjustments, ordering investigations and arranging referrals as appropriate, with a follow-up appointment then booked in clinic. If you would prefer to implement the recommendations yourself, please check this box.

Please check here to indicate that you have informed your patient that, by law, **DRIVING SAFETY WILL BE PART OF THE ASSESSMENT**

Please check here to indicate that you **both recommend AND have** the patient's verbal **consent** for the MINT Memory Clinic team **to contact an alternate person** in order to arrange this appointment. If so, please include:  
Alternate Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone Number(s): \_\_\_\_\_ and/or \_\_\_\_\_

**Reason for Referral:**  
 Cognition / Dementia  
 Depression / Anxiety  
 Responsive Behaviours  
 Delusions / Hallucinations  
 Other / Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please attach any recent investigations including:**  
 CBC  Glucose  
 TSH  HbA1C  
 Creatinine  Vitamin B12  
 Sodium  Calcium  
 MRI or CT of the brain

Referring Physician:  
Signature:

Billing #:  
Date:

