300 Silver Star Blvd, 2nd floor
Scarborough, ON M1V 0G2
Phone: 416-847-8941 Fax: 416-646-5111

REFERRAL FORM – Scarborough MINT Memory Clinic Collaborative Care Services

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 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:	Billing #:
Signature:	Date:

seniors care network

MINT MEMORY CLINIC
Collaborative primary care
(Formerly PCCMS)

Alzheimer Society DURHAM

Ontario Local Health Integration Network