Alzheimer Society DURHAM REGION
seniors care network
Dr. V. Ho Dr. H. Burke Dr. A. Haider
Dr. K. De Luna Dr. P. Bharucha

MINT MEMORY CLINIC
Collaborative primary care
(Formerly PCCMS)

Clarington Site
222 King Street East,
West Wing, 2nd Floor, Suite 2200
Bowmanville, ON L1C1P6

BOWMANVILLE HEALTH CENTRE

Phone: 905-576-2567 ext.5235 Fax: 888-573-6653

REFERRAL FORM – Clarington Site

LAST NAME: FIRST NAME:

HC#: VC: DOB: ☐ M ☐ F

ADDRESS:

PHONE: CELL:

☐ **RECOMMENDATIONS ONLY** – rather than our routine management which includes medication adjustments, ordering investigations and arranging referrals as appropriate, please check to indicate that you would prefer recommendations only from the Memory Clinic team.

☐ Please check here to indicate that the patient has been informed 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 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:	**Please attach any recent investigations including:**
☐ Cognition / Dementia	☐ CBC ☐ Glucose
☐ Depression / Anxiety	☐ TSH ☐ HbA1C
☐ Responsive Behaviours	☐ Creatinine ☐ Vitamin
☐ Delusions / Hallucinations	☐ Sodium B12
☐ Other / Comments:	☐ MRI or CT of the brain

Referring Physician:	Billing #:
Signature:	Date: