Grand River Community Health Centre
363 Colborne Street Brantford On. N3S 3N2
Telephone: (519) 754-0777 Fax: 519-754-0757

Memory Clinic Referral

Client Name:	Date of Birth:	Telephone:
Address (**must live in Brantford / Brant County**):	City:	Postal Code:

Health Card Number:	VC (if applicable):

Client/family aware referral has been made? ☐ Yes ☐ No
Contact Name and Phone Number if different from above:
Is client being seen /followed by the Seniors Mental Health Outreach Program or geriatrician? ☐ Yes ☐ No

Reasons for Referral (please check **and** describe):

☐ Cognition / Dementia _____

☐ Depression / Anxiety _____

☐ Behavioural Difficulties (e.g. Wandering) _____

☐ Delusions / Hallucination_____

☐ Caregiver Stress/ Psychosocial concerns: _____

☐ Other: _____

Mandatory for Referral (please check and include)**:**

☐ Non-Urgent ☐ Urgent **Must provide reason:** _____

☐ Current medication list (Medscheck done by pharmacy preferred)

☐ Significant medical history

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

☐ Patient has a primary care provider who can follow up on recommendations made by the Memory Clinic

Optional for Referral (please include if available):

☐ CT Scan / MRI

☐ ECG

☐ Any Consult report/ Specialist report

☐ Blood work including CBC, Creatinine, Glucose, Calcium, TSH, Vit B12, Albumin, Liver function tests

Comments:

Physician Name:	Physician Number:
Physician Signature:	Date:
Primary Care Provider (if different than referring physician):	