SOINS CONTINUS Bruyère CONTINUING CARE

# BRUYÈRE MEMORY PROGRAM

**Exclusion criteria:** Ours is a dementia diagnostic and treatment clinic. We are unable to process cases that: coincide with an acquired brain injury, documented neurological disorder (e.g. M.S.), active substance abuse, inadequately controlled psychiatric illness, or longstanding learning disabilities. Patients < 50 years are only seen under special circumstances.

## Referral will not be processed without the following: (please attach)

☐ Complete bloodwork/Urinalysis results (within last 3 months): CBC, Electrolytes, Creatinine/eGFR, Glucose (Random), ALT, Calcium, Vitamin B12, TSH, Ferritin, VDRL/Syphilis Serology, Urinalysis (Chemical)

**AND**

☐ CT or MRI Head results (within last 2 years) OR Proof of Ordered/Pending CT or MRI Head

| **Client's Last Name:** | Given Name: | Health Card | Code |
|---|---|---|---|
| Address | City/Province | Postal Code | |
| Telephone No. | Date of Birth (day/mo/yr) | Marital Status | Language | Gender |

Living Arrangements: ☐ Alone ☐ Spouse ☐ Other Relative ☐ Friend ☐ Residential ☐ Other

| **Name of Contact Person:** | Relationship | Home Telephone No. | Work Telephone No. | Cell No. |
|---|---|---|---|---|
| Address | City/Province | Postal Code | | |

Who should be contacted for the appointment? ☐ Client or ☐ Contact person

| **Family Physician:** | Telephone No. | **Fax No.** |
|---|---|---|
| Address | City/Province | Postal Code |

Date Last Seen: Client Aware of Referral? ☐ Yes ☐ No

**Referral Source: (if other than family physician)** Name/Agency

Telephone No. **Fax No.**

**Reason for Referral:**

**Medical History:**

**List of Current Medications:** (Name/Dosage)

**Please enclose pertinent diagnostic investigations /assessment report (within last year)**

| **Signature of Referring Physician:** | **Physician Billing No.:** |
|---|---|
| Printed name of Referring Physician: | **Date of Referral:** |

**FAX TO: 613-562-6013 Tel: 613-562-6322**
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