Bruyère

BRUYERE MEMORY PROGRAM
CLINIC REFERRAL FORM

We are a dementia diagnostic and treatment clinic for undiagnosed patients with mild or atypical cognitive decline in which neurodegeneration is suspected. Our mandate is for early diagnosis and intervention.
WE DO NOT PROVIDE LONG-TERM FOLLOW-UP.

Client information

Client's Last Name: | Given Name: | Health Card | Code

Address | City/Province | Postal Code

Telephone No. | Date of Birth (day/mo/yr) | Marital Status | Gender

Gender

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

Language: ☐ English ☐ French ☐ Other:

Is there a language barrier? ☐ Yes ☐ No Is interpreter needed? ☐ Yes ☐ No

Name of Contact Person: | Relationship | Phone No.

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

We only accept referrals for patients aged 50+ for diagnostic assessment and initiation of treatment for whom the following apply:

Mandatory Checklist: MUST check ALL or referral will not be accepted:

- ☐ **Patient has undiagnosed mild or atypical cognitive decline (with minimal or mild functional impairment) in which neurodegeneration is suspected, with the goal of referral being early diagnosis and intervention.**
- ☐ **There is no recent medical event, delirium, stroke, traumatic brain injury, or uncontrolled neurologic illness (e.g. seizure disorder, multiple sclerosis)**
- ☐ **There is no frailty, falls, multiple medical co-morbidities, or polypharmacy for which Geriatric Day Hospital consultation is better suited (refer to Geriatric Central triage see link) Medical office registration form (rgpeo.com)**
- ☐ **There is no uncontrolled psychiatric disorder for which Psychiatry or Geriatric Psychiatry consultation is better suited (refer to centralized geriatric psychiatry see link) Joint Referral ROH-GPCSOEn_p1**
- ☐ **There is no alcohol and/or substance use disorder to explain the patient's cognitive symptoms**
- ☐ **I have confirmed that the required labs (see below) have been done and reviewed in primary care. These have been deemed to be non-contributory (i.e., no reversible cause for cognitive symptoms has been identified)**
- ☐ **Attached: Bloodwork and Urinalysis results within last 3 months of referral (CBC, Electrolytes, HbA1c, Creatinine/eGFR, ALT, Ionized Calcium, Vitamin B12, TSH, Ferritin, Urinalysis (Chemical)**
- ☐ **Attached: CT or MRI Head results within last 2 years, or Proof of ordered/pending CT or MRI Head**
- ☐ **Attached: List of current medications and dosages**
- ☐ **Attached: copies of prior dated cognitive testing if available**

Mandatory: **Describe the reason for referral and basis for suspicion for emerging neurodegeneration:**

Additional concerns:

☐ function ☐ caregiver stress ☐ driving ☐ other safety concerns

Medical History: (Please Include copies of relevant consultation e.g., neurology, psychiatry)

☐ Down's Syndrome or intellectual disabilities

Primary care provider: Name: Phone: Fax: ☐ no PCP

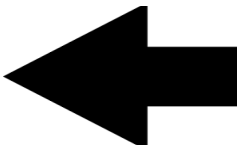
Referral Source if other than PCP: Name: Phone: Fax:

Signature of Referring Physician/ Nurse practitioner:

Printed name of referring Physician:

Physician Billing No.:

Date of referral:



ALL FIELDS REQUIRED

Contact us:

Office Hours

8:00 am to 4:00 pm
Tel.: 613-562-6322
Fax: 613-562-6013

Address

75 Bruyère St, Suite 110Y
Ottawa, Ontario
K1N 5C8