Champlain LHIN
RLISS de Champlain

FAX: 613-745-6497

Cornwall or Winchester Memory Disorder Clinic
Referral Screening Form for Eligibility and Intake

Patient under 60 years, refer to the Elisabeth- Bruyere Health Centre Memory Disorder Clinic.
Patient living in Long Term Care Facility, refer to the Specialized Geriatric Psychiatry Team.

Referring Physician: _____	Family Physician: _____
Address: _____	Address: _____
Telephone Number: _____	Telephone Number: _____
Patient Name: _____	Date of Birth: _____ Age: _____
Language of Preference: _____	Sex: _____
Address: _____ Living Arrangements? ☐ Alone ☐ With family	
Telephone Number: _____	Ontario Health Card Number: _____ Medic Alert: _____

Memory Problems: _____
☐ Gradual ☐ insidious onset?
Cognitive deficits interfere with ☐ social ☐ occupational ☐ ADL functioning?

Has patient had any recent investigations, (CT, blood work, ECG)? _____
Involvement of Psychogeriatric Services? _____
Other agency involvement? _____

Contact Person: _____	Relationship: _____
Address: _____	Telephone Number: _____

Reason for referral? _____
☐ Urgent ☐ Non-urgent

_____ _____
Referring Physician Signature Date of Referral