Toronto Memory Program

Research Referral Form

Fax to (416) 386-0458

Patient Identification
Name:
Address:
Telephone:
DOB:
HCN:

Contact Person
Name:
Relationship:
Telephone (H):
Telephone (B):
Mobile:
Email:

Clinical Trials (ages 50-90 years)

- ❑ Alzheimer's disease (Age 50-90, prevention, MCI, dementia)
- ❑ Parkinson's disease (Age 50-85)
- ❑ Migraine (Age 18+)
- ❑ Interest in a specific trial: _____

Past Medical History and Medications (please attach CPP)

Investigations to date: (please forward in advance of appointment if available):

❑ Blood work (including TSH and B12) ❑ CT brain or MRI brain ❑ ECG
❑ Cognitive test results ❑ Relevant consultation notes ❑
Other_____

Referring MD:
Billing No:
Signature:

Phone:
Fax No:
Email:

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